

OFFICE OF THE STATE CONTROLLER

STATE MANDATED COSTS CLAIMING INSTRUCTIONS NO. 99-2

47-DAY CLAIMS - 7/1/97 to 8/16/97

Chapter 780, Statutes of 1998 (Local Government Claims Bill SB 1855) appropriated \$4,114,000 to the State Controller's Office to reimburse local agencies for costs incurred in complying with certain State-mandated programs (i.e., 47-day claims) during the period July 1, 1997, to August 16, 1997. These 47-day claims are the result of the delay in the enactment of the 1997 State Budget Bill AB 107 (Chapter 282, Statutes of 1997). Because of the delayed budget act, local agencies were required to comply with certain State-mandated programs through August 16, 1997. After this date, the programs were suspended by the 1997 Budget Act; therefore, no claims shall be submitted for costs incurred after August 16, 1997.

Reimbursement claims detailing the actual costs incurred for the period July 1, 1997, through August 16, 1997, must be filed with the State Controller's Office. *Claims must be delivered or postmarked on or before June 25, 1999.* Claims filed after the deadline will be reduced by a late penalty of 10%, not to exceed \$1,000. In order for a claim to be considered properly filed, it must include supporting documentation as specified in the instructions, substantiating the costs claimed. In addition, the functions performed by each employee for whom costs were claimed must be explained. *Claims filed more than one year after the deadline, or without supporting documentation, will not be accepted.*

Minimum Claim Cost

Government Code Section 17564(a) provides that no claim or payment shall be made pursuant to Section 17561 unless such a claim exceeds \$200 per program per fiscal year. However, any county, as a fiscal agent, may submit a combined claim in excess of \$200 on behalf of special districts within the county, even if an individual district's claim does not exceed \$200. A combined claim must show the individual claim costs for each special district. Once a combined claim is filed, all subsequent fiscal years relating to the same mandate must also be filed in a combined form. The county is responsible for disbursing funds to each participating district. A special district may withdraw from a combined claim by providing the county and the State Controller's Office with a written notice of its intent to file a separate claim at least 180 days prior to the claims filing deadline.

Reimbursement Claims

Reimbursement claims for actual increased costs may only be filed for those costs that are supported by documentation providing evidence of the validity of the expenditures including, but not limited to, employee time records, invoices, receipts, contracts, and purchase orders. No claim for costs shall be filed without supporting documentation.

Reimbursable State-mandated Cost Programs

Listed below are reimbursable State-mandated local programs for the period 7-1-97 to 8-16-97. The "X" indicates which local agency type is eligible to file a claim for program costs. Programs contained in this package are arranged in ascending statute/chapter order.

Program Names				Cities	Counties	Special Districts
1	Ch.	1330/76	Local Coastal Plans	X	X	
2	Ch.	1357/76	Guardianship/Conservatorship		X	
3	Ch.	77/78	Absentee Ballots ¹			
4	Ch.	845/78	Filipino Employee Survey	X	X	
5	Ch.	494/79	Handicapped Voter Access		X	
6	Ch.	1032/80	Deaf Teletype Equipment		X	
7	Ch.	1281/80	Involuntary Lien Notices		X	
8	Ch.	332/81	Victim Statements, Minors		X	
9	Ch.	980/84	Court Audits and Proration of Fines		X	
10	Ch.	1609/84	Domestic Violence Information	X	X	
11	Ch.	1042/85	Election Materials ²			
12	Ch.	48/87	Property Taxation: Family Transfers		X	
13	Ch.	1334/87	CPR Pocket Masks	X	X	X
14	Title 8, CCR		Personal Alarm Devices	X	X	X
15	Title 8, CCR		Structural and Wildland Firefighter Safety Clothing and Equipment	X	X	X
¹ No claim shall be filed for Absentee Ballots. Absentee Ballots is an on-going program for the period 7-1-97 to 8-17-97 and costs were claimable under Claiming Instructions No. 97-7 and 98-4, dated October 22, 1997, and February 17, 1998, respectively.						
² No claim shall be filed for Election Materials. This mandate was repealed January 1, 1992, by its own term in Ch. 1042/85.						

Appropriations for State-mandated Cost Programs for the Period 7/1/97 to 8/16/97

Program Names				Appropriations
1	Ch.	1330/76	Local Coastal Plans	\$3,000
2	Ch.	1357/76	Guardianship/Conservatorship	296,000
3	Ch.	77/78	Absentee Ballots	155,000
4	Ch.	845/78	Filipino Employee Survey	1,000
5	Ch.	494/79	Handicapped Voter Access	35,000
6	Ch.	1032/80	Deaf Teletype Equipment	4,000
7	Ch.	1281/80	Involuntary Lien Notices	38,000
8	Ch.	332/81	Victim Statements, Minors	256,000
9	Ch.	980/84	Court Audits and Proration of Fines	195,000
10	Ch.	1609/84	Domestic Violence Information	1,482,000
11	Ch.	1042/85	Election Materials	3,000
12	Ch.	48/87	Property Taxation: Family Transfers	38,000
13	Ch.	1334/87	CPR Pocket Masks	14,000
14	Title 8, CCR		Personal Alarm Devices	693,000
15	Title 8, CCR		Structural and Wildland Firefighter Safety Clothing and Equipment	901,000
Total Appropriations				\$4,114,000

Claiming of Costs

Refer to the instructions in the *Mandated Cost Manual* for claiming of direct and indirect costs and preparation of claims for submission to the State Controller's Office. The following instructions on how certain direct costs may be claimed pertain only to 47-day claims.

Personal Services

The cost of salaries and employee benefits for time spent performing mandated activities by employees during the period 7-1-97 through 8-16-97 are reimbursable. Any time spent outside the time period is not reimbursable. Example: an employee started working on the mandate on 7-15-97. Completion date was 8-26-97. In this case, the cost for time spent 7-15-97 through 8-16-97 is reimbursable. The cost for time spent 8-17-97 through 8-26-97 is not reimbursable.

Contract Services

Reasonable cost of contract services for mandated activities performed during the period 7-1-97 through 8-16-97 are reimbursable. The costs for contract services outside the time period are not reimbursable. Example: a consultant started working on the mandate 7-15-97. Completion date was 8-26-97. In this case, the cost of contract services time spent 7-15-97 through 8-16-97 is reimbursable. The cost of contract services time spent 8-17-97 through 8-26-97 is not reimbursable. Or, in this example, only a portion of the contract cost is reimbursable. The amount of reimbursement for the services would be the proration of the contract cost for time spent within the reimbursable time period proportionate to the total time spent for the contract. Attach a copy of the contract along with documentation showing total time spent on the contract

and the amount of time spent within the reimbursable time period. Reimbursement for contract services cannot be based on the date when the local agency entered into a service contract, but rather when the service was performed.

Equipment and Materials

--Ch. 1334/87 CPR Pocket Masks

--Title 8, CCR Personal Alarm Devices

--Title 8, CCR Structural and Wildland Firefighters Safety Clothing and Equipment

These three mandated programs are unique in that they require local agencies to have certain types of equipment and materials for performance of activities. A local agency is reimbursed for the cost of the purchased item rather than its use or consumption. A purchased item is eligible for reimbursement if any of the following occurred during the period 7-1-97 through 8-16-97:

(a) purchase order for the item was submitted to the vendor, (b) receipt of the purchased item, or (c) payment of the purchased item. Attach documentation to show that the activity for the purchased item was within the reimbursable time period.

Materials and supplies used for other mandates are ancillary in nature. The mandate does not require a purchase of specific materials and supplies, but such items may be needed by an employee in order to perform the mandated activity. Reimbursable material and supply costs for these mandates are for those items that have been consumed, expended, or used specifically for the purpose of the mandate during the period 7-1-97 through 8-16-97. Unused items are not reimbursable.

Audit of Costs

All claims submitted to the State Controller's Office are reviewed to determine if costs are related to the mandate, are reasonable and not excessive, and if the claim was prepared in accordance with the claiming instructions. If any adjustments are made to a claim, a "Notice of Claim Adjustment" (specifying the claim component adjusted, the amount adjusted, and the reason for the adjustment) will be mailed within 30 days after payment of the claim.

On-site audits will be conducted by the State Controller's Office as deemed necessary. Accordingly, documentation to support actual costs claimed must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended. When no funds are appropriated for initial claims at the time the claim is filed, supporting documents must be retained for two years from the date of initial payment of the claim.

Claim documentation shall be made available to the State Controller's Office on request.

Retention of Claiming Instructions

The claiming instructions and forms in this package should be retained permanently in your *Mandated Cost Manual* for future reference and use in filing claims. These forms should be duplicated to meet your filing requirements. Each year, the State Controller's Office will send

updates on forms as well as any other information or instructions necessary to file claims. When new program costs are claimable, instructions will be sent to claimants.

For your reference, these and future mandated costs claiming instructions and forms can be found at the Controller's Office Web site at **www.sco.ca.gov**.

Filing Deadlines for Other Mandated Programs

Estimated and reimbursement claims may still be filed for the following State-mandated programs (for which claiming instructions were issued by this office).

Claiming Instructions No. 98-14, filing deadline March 30, 1999, for three mandated cost programs: Ch. 1143/80, Regional Housing Need Determination; Ch. 1297/94, Two-Way Traffic Signal Communication; and Ch. 762/95, Sexually Violent Predators.

Claiming Instructions No. 99-1, filing deadline June 16, 1999, for the mandated program Ch. 183/92, Domestic Violence Treatment Services - Authorization and Case Management.

Other Comments

The claiming instructions contained within this package are issued for the sole purpose of assisting local agencies with the preparation of claims for submission to the State Controller's Office. Adherence to these instructions will expedite the payment process. These instructions were prepared based on interpretation of the statutes, regulations, standards, and parameters and guidelines adopted by the Commission on State Mandates. Therefore, unless otherwise specified, these instructions should not be construed in any manner to be statutes, regulations, or standards. All claims received by this office will be reviewed to verify the actual amount of mandated costs. Claims may be reduced if determined to be excessive, improper, or unreasonable.

Address for Filing Claims

For each program, submit a signed original and a copy of form FAM-27, Claim For Payment, and a copy of all other forms and supporting documents to:

If delivery is by
U.S. Postal Service:

Office of the State Controller
Attn: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

If delivery is by
other delivery services:

Office of the State Controller
Attn: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

If you have any questions pertaining to mandated cost reimbursements, please write to the above address, fax to (916) 323-6527, or call the Local Reimbursements Section at (916) 323-3258.

CALIFORNIA LOCAL COASTAL PROGRAMS

1. Summary of Chapter 1330/76

The California Coastal Act of 1976 requires coastal cities and counties to prepare Local Coastal Programs (LCP's) for the portion of their jurisdiction within the coastal zone. Generally, an LCP consists of a land use plan and the land use controls, such as zoning ordinances, necessary to implement the land use plan. Most local governments will prepare their LCP's with grants approved by the California Coastal Commission. However, for reasonable and necessary LCP preparation costs not covered by a grant, the State Mandated Costs Account (SB 90), pursuant to Government Code Section 17561, provides other reimbursement funds to local governments. Chapter 1075, Statutes of 1978, established procedures and requirements local governments must comply with in order to claim and receive State reimbursement of costs mandated by, and directly attributable to, the California Coastal Act of 1976.

2. Eligible Claimants

Any coastal city or county that incurs increased costs as a direct result of this mandate is eligible to claim reimbursement of these costs.

3. Reimbursement

Eligible claimants will be reimbursed for costs incurred during the period 7/1/97 through 8/16/97. There are two classifications of reimbursable costs:

- A. Direct planning and administrative costs related to the preparation, review, and certification of a local coastal program or any portion thereof.

Direct planning and administrative costs include costs incurred for identification of issues to be addressed in an LCP, preparation of an LCP work program for Coastal Commission review and approval, and completion of approved work program tasks. Costs for the latter must be for work reasonable and necessary for the preparation and certification of a local coastal program prepared pursuant to the approved work program. Costs for work not part of a Commission approved work program are eligible if the work is shown to be necessary for completion of a certifiable LCP or if the Commission, on the basis of new information, requires such work to be done.

- B. Costs related to the implementation of a certified local coastal program.

Implementation costs eligible for reimbursement are identified in Coastal Act Section 30353 and are summarized below:

- (1) Costs for establishing a regulatory program to implement a certified LCP through start-up measures such as the preparation and printing of public information materials, application forms, establishing new procedures, and staff training are limited to those incurred over a period not to exceed one year from the date a local government has adopted its certified LCP for implementation.
- (2) General costs for processing coastal permit applications (e.g. costs for public notice, submittal of files to the Commission, and appearances before the Commission on appeals). This will be a fixed payment, not to exceed 10 dollars per application.

- (3) Increased regulatory costs where a local government can show either or both of the following circumstances apply within its jurisdiction:
 - (a) In jurisdictions with a population of less than 10,000, the existing regulatory program of the local government is not capable of processing and reviewing additional coastal development permits pursuant to a certified local coastal program and where such increased costs could not reasonably be expected to be covered by permit fees;
 - (b) The regulatory program included in a certified local coastal program requires the discharge of resource management functions that exceed the level of regulatory review normally required or undertaken by the local government.
 - (4) Enforcement costs attributable to LCP implementation, such as assuring compliance with coastal permit conditions (if such enforcement is not routinely performed or already required by law as part of a local government's normal regulatory responsibilities).
 - (5) Litigation costs incurred for the operation of a certified local coastal program that would not have been incurred otherwise, may be paid. Where an action is brought against a local government and such action states, as a principal cause of action, the operation of such government's local coastal program and the local government prevails in such action, litigation costs may be paid to the extent such costs are not assessed against the party bringing the action. Where the local government loses such action primarily on grounds it has failed to properly carry out its certified local coastal program, litigation costs shall not be paid.
 - (6) Costs for additional planning required by the Commission as a condition of its certification of an LCP.
- C.** Costs in both reimbursable cost classifications A and B must:
- (1) Be the direct result of, and be mandated by, the operation of the Coastal Act or by the Coastal Commission;
 - (2) Not be paid for, or reimbursed from any other source of state or federal funds; and
 - (3) Not be for work that is optional.

4. Reimbursement Limitation

A. Costs Not Eligible for Reimbursement

Costs claimed for tasks that are not substantiated by task products and accounting records are not eligible for reimbursement. Other non-reimbursable costs are:

- (1) Costs totaling less than two hundred dollars (\$200);
- (2) Costs not related to the preparation, review, and approval of an LCP or otherwise mandated by the Coastal Act or the Commission (i.e., costs of completion or updating general plan elements already mandated by state law);
- (3) Costs associated with LCP amendments, unless the amendment is for mandated work such as LCP land use and zoning designations prepared for an area newly annexed to the claiming jurisdiction;
- (4) Costs associated with Coastal Act Boundary Study;
- (5) Costs of salaries for a City Manager or County Administrator that are ongoing costs of local government; costs associated with inappropriate or inefficient use of high level staff to do work appropriate for lower levels.

The above examples of non-reimbursable costs are illustrative only, there may be other grounds for denial of a claim.

- B.** Any offsetting savings or reimbursement the claimant received from any source including, but not limited to, service fees collected, federal funds, and other state funds as a result of this mandate, shall be identified and deducted so only the net local cost is claimed.

5. Instructions for Completing Attached Claim Forms

Coastal Act related claims are divided into four categories:

- A.** Issue Identification and preparation of a Work Program for the LCP.
- B.** Preparation of the Land Use Plan.
- C.** Preparation of Land Use Controls, such as zoning ordinances, to implement the land use plan.
- D.** Implementation Costs (e.g., start-up measures, permit processing, etc.).

A separate four-page Mandated Costs Claim Form (attached pages CF-1 through CF-4) must be completed for each claim category (e.g., one form for the Land Use Plan cost claims and another form for Land Use Controls cost claims; this office will accept photocopies of the attached blank form to use for each category claimed).

All claimed costs should be rounded to the nearest dollar.

The Summary and Certification (attached page CF-5) must be completed, with signature. The page must list the totals of all actual costs and previous reimbursements detailed in the claim form(s).

If you are reporting actual costs over and above those covered by a Local Coastal Program Grant that included funding for work in the 7/1/97 through 8/16/97 claim period, you must report the total cost for the claim category and reduce the cost by the amount budgeted in the approved grant's work program.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office or the Coastal Commission on request.

<p align="center">CLAIM FOR PAYMENT Pursuant to Government Code Section 17561 CALIFORNIA LOCAL COASTAL PROGRAMS</p>		<p align="center">For State Controller Use Only</p>									
		(06) Program Number 00037 (07) Date File _____/_____/_____ (08) LRS Input _____/_____/_____									
LABEL HERE	(01) Claimant Identification Number										
	(02) Mailing Address										
	Claimant Name										
	County of Location										
	Street Address or P. O. Box										
	City	State		Zip Code							
(03) <u>REIMBURSEMENT CLAIM</u>		<u>COST FOR CLAIM PERIOD</u> <u>7/1/97 - 8/16/97</u>									
I. Issue Identification/Work Program II. Land use Plan III. Land Use Controls IV. Implementation Costs (including coastal permit processing costs) Subtotal Less Grants or Other Reimbursements Received Less 10% Late Penalty AMOUNT CLAIMED		_____ _____ _____ _____ _____ _____ \$ _____									
(04) CERTIFICATION OF CLAIM In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1330, Statutes of 1976; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive. I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1330, Statutes of 1976. The amount of the Reimbursement Claim is hereby claimed from the State for payment of actual costs for the mandated program of Chapter 1330, Statutes of 1976, set forth on the attached statements. <table border="0"> <tr> <td>Signature of Authorized Representative</td> <td>Date</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>Type or Print Name</td> <td>Title</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>				Signature of Authorized Representative	Date	_____	_____	Type or Print Name	Title	_____	_____
Signature of Authorized Representative	Date										
_____	_____										
Type or Print Name	Title										
_____	_____										
(05) Name of Contact Person for Claim		Telephone Number (____) _____ Ext. _____									

CALIFORNIA LOCAL COASTAL PROGRAMS Certification Claim Form Instructions	FORM FAM-27
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- (01) Leave blank.
- (02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the place shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.
- (03) **A separate form is needed for each claim category .**
- I. Issue Identification/Work Program. Enter the total cost of this claim category from page CF-5.
- II. Land Use Plan. Enter the total cost of this claim category from page CF-5.
- III. Land Use Controls. Enter the total cost of this claim category from page CF-5.
- IV. Implementation Costs. Enter the total cost of this claim category from page CF-5.
- If a reimbursement claim is filed after **June 25, 1999**, the claim must be reduced by a late penalty. Enter 10% penalty or \$1,000, whichever is less.
- (04) Read the statement, "Certification of Claim." If the statement is true, the claim must be dated, signed by the agency's authorized representative, and must include the person's name and title, typed or printed Claims cannot be paid unless accompanied by a signed certification.
- (05) Enter the name of the person and telephone number that this office should contact if additional information is required.
- (06) to (08) No entry required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

*Address, if delivered by
U.S. Postal Service:*

OFFICE OF THE STATE CONTROLLER
 ATTN: Local Reimbursements Section
 Division of Accounting and Reporting
 P.O. Box 942850
 Sacramento, CA 94250

*Address, if delivered by
other delivery service:*

OFFICE OF THE STATE CONTROLLER
 ATTN: Local Reimbursements Section
 Division of Accounting and Reporting
 3301 C Street, Suite 500
 Sacramento, CA 95816

MANDATED COSTS CLAIM FORM**COASTAL ACT OF 1976**

Jurisdiction Name _____

Date Submitting Claim _____

A. Claim Categories (circle one; use a separate form for each claim category):

1. Issue Identification/Work Program
2. Land Use Plan
3. Land Use Controls
4. Implementation Cost (e.g., permit processing, start-up measures, etc.)

B. Project Dates:

Project Started: _____

Project Completed: _____

C. Amount of any grant authorized for this project and grant dates: _____**D. Amount reimbursed for this project or any portion thereof, pursuant to a mandated costs claim previously submitted (FY 76/77 through FY 97/98) _____****E. CURRENT CLAIM SUBSTANTIVE INFORMATION**

Responses to all of the following questions must be provided in the spaces below or on separate pages for each category of costs and for each work task item for which a claim is submitted. Failure to respond to all four of these questions may result in a negative recommendation to the Controller.

1. Describe how costs claimed during the period 7/1/97 through 8/16/97 relate to the Coastal Act of 1976 mandates, or to the work program of a Coastal Commission grant. Be specific as to which provision(s) of the Coastal Act is addressed, by the task of a work program undertaken during the period 7/1/97 through 8/16/97.

E. COST BREAKDOWN BY CATEGORIES**1. Coastal Permit Processing Cost****2. Salaries and Benefits**

Following the entry(ies) below for the total costs in this category, identify the employee(s), and/or show the classification of the employee(s) involved. Describe the specific functions performed by each employee and specify the actual time spent, the productive hourly rate, and related fringe benefits.

Source documents to be maintained by the claimant may include, but are not limited to, employee time records that show the employee's actual time spent on this mandate.

Actual Costs
7/1/97 - 8/16/97

3. Contract Services

Following the entry(ies) below for the total costs in this category, show the name of each consultant, describe reasons for hiring consultants, specify functions consultants performed relative to the mandate, length of appointment, and itemized costs for such services. Indicate other work consultant performed for your jurisdiction during this period.

Contracting costs are reimbursable to the extent that the function to be performed requires special skill or knowledge that is not readily available from the claimant's staff or the service to be provided by the contractor is cost effective.

Source documents to be maintained by the claimant may include, but are not limited to, contracts, invoices, and other documents evidencing the validity of the expenditures.

Actual Costs
7/1/97 - 8/16/97

4. Supplies

Only expenditures identified as a direct cost resulting from the mandate can be claimed. Following the entry(ies) below, list the itemized cost of materials acquired, consumed, or expended for the purpose of that phase of work.

Source documents to be maintained by the claimant may include, but are not limited to, invoices, receipts, purchase orders, and other documents evidencing the validity of the expenditure.

Actual Costs
7/1/97 - 8/16/97

5. Travel

Travel expenses for mileage, per diem, lodging, and other employee entitlements are paid in accordance with rules of the local jurisdiction. Give the name(s) of the traveler(s), purpose of travel, inclusive travel dates, destination points, and costs.

Source documents to be maintained by the claimant may include, but are not limited to, receipts, employee travel expense claims, and other documents evidencing the validity of the expenditures.

Actual Costs
7/1/97 - 8/16/97

6. Equipment

Compensation for use of equipment is allowable through a use allowance or depreciation during the period it is assigned to the work-phase. A use allowance may be computed at an annual rate not to exceed 6 2/3% of acquisition cost. This is reported and claimed through the agency's service-wide cost allocation plan under the cost element "Use Allowance." Where a depreciation method is followed, adequate property records must be maintained and any generally accepted method of computing depreciation may be used.

Source documents to be maintained by the claimant may include, but are not limited to, invoices, receipts, purchase orders, and other documents evidencing the validity of the purchases.

Actual Costs
7/1/97 - 8/16/97

7. Allowable Indirect Overhead Costs
(State % used)

Cities and counties have the option of using 10% of direct labor as indirect costs or an indirect cost rate prepared in accordance with provisions of Office of Budget Management Circular No. A-87, Principles for Determining Costs Applicable to Grants and Contracts. Indirect costs may include costs of space, equipment use, utilities, insurance, administration, etc. The indirect cost rate used must be shown on the claim. If any indirect costs claimed are at a rate different than one used in a Commission grant that included funding for work in the 7/1/97 through 8/16/97 claim period, the difference must be explained.

Actual Costs
7/1/97 - 8/16/97

TOTAL OF COST
CATEGORIES 1-7: \$ _____

GUARDIANSHIP AND CONSERVATORSHIP FILINGS

1. Summary of Chapter 1357/76

Chapter 1357, Statutes of 1976, revised and expanded the provisions of law governing procedures for the creation of a relationship of guardian and ward, and the establishment of conservatorship in instances where an adult person by reason of his/her advanced age, illness, injury, mental weakness, intemperance, addiction to drugs, or any other disability or cause is unable to properly care for himself/herself or his/her property. As a result, the statute provides for the appointment of a counsel to represent the interests of a proposed ward or conservatee under designated circumstances, trial by jury on the issue of whether a wardship or conservatorship should be established, a court appointed investigator to interview the potential ward or conservatee if such person is certified as unable to attend hearing proceedings, and a court investigator to annually review each guardianship and conservatorship initiated pursuant to this statute.

Chapter 1357, Statutes of 1976, was consolidated and renumbered by the provisions of Chapter 726, Statutes of 1979. These guidelines reflect the changes in this statute.

2. Eligible Claimants

Any county that has incurred increased costs as a direct result of this mandate is eligible to claim reimbursement of these costs.

3. Reimbursable Components

Eligible claimants will be reimbursed for costs incurred during the period 7/1/97 through 8/16/97 for the following activities:

A. Court Appointed Counsel

The cost of a court appointed counsel is reimbursable, if the proposed ward or conservatee is unable to retain legal counsel in a guardianship or conservatorship proceeding.

B. Pre-hearing and Review Hearing Investigations

The cost of court appointed investigators, who make certain pre-hearing investigations and review cases after one year and biennially thereafter, is reimbursable.

C. Jury Trial

The cost of the jurors for a jury trial, where the issue is whether a wardship or conservatorship should be established, is reimbursable.

D. Public Guardian and County Counsel

The cost of the public guardian and county counsel is reimbursable if they are able to document the time spent on cases in which the public guardian was appointed as conservator due to the court investigator's findings. Such costs would be eligible for

reimbursement to the extent costs exceed any other court-directed function or any payment received from the estate of the conservatee.

Reimbursable costs must be reduced by the amount of fees collected from parents, guardians, proposed ward's estate, or conservatee's estate for services rendered.

4. Reimbursement Limitations

Any offsetting savings or reimbursement the claimant received from any source including, but not limited to, service fees collected, federal funds, and other state funds as a result of this mandate, shall be identified and deducted so only the net local cost is claimed.

Costs related to "court operations" as defined in Government Code Section 77300 are not reimbursable when the county opts for the Trial Court Funding Program pursuant to Section 77300. In light of Government Code Section 77003, the costs associated with court appointed investigators and any costs for a jury trial shall not be claimed if the county is participating in the Trial Court Funding Program. Pursuant to Section 77203, block grant disbursements to the county shall be in lieu of any reimbursement of state mandated local programs for trial courts during the fiscal years in which it is a participant of the program.

No cost shall be claimed for cases classified under Lanterman-Petris-Short.

5. Claiming Forms and Instructions

The diagram, "Illustration of Claim Forms," provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for forms GCF-1 and GCF-2 provided the format of the report and data fields contained within the report are identical to the claim forms included in these instructions. The claim forms provided with these instructions should be duplicated and used by the claimant to file reimbursement claims.

A. Form GCF-2, Component/Activity Cost Detail

This form is used to segregate the detailed costs by claim component. A separate form GCF-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed and specify the actual time devoted to each function by each employee, productive hourly rate, and related fringe benefits.

Reimbursement for personal services includes compensation paid for salaries, wages, and employee fringe benefits. Employee fringe benefits include regular compensation paid to an employee during periods of authorized absences (e.g., annual leave, sick leave) and the employer's contribution of social security, pension plans, insurance, and worker's compensation insurance. Fringe benefits are eligible for reimbursement when distributed equitably to all job activities which the employee performs.

Source documents may include, but are not limited to, time logs evidencing actual costs claimed under Reimbursable Activities, time sheets, payroll records, canceled payroll warrants, organization charts, duty statements, pay rate schedules, and other documents evidencing the expenditure.

(2) Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of the materials and supplies consumed specifically for the purposes of this mandate. Purchases shall be claimed at the actual price after deducting cash discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged based on a recognized method of costing, consistently applied.

Source documents may include, but are not limited to, general and subsidiary ledgers, invoices, purchase orders, receipts, canceled warrants, inventory records, and other documents evidencing the expenditure.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later.

B. Form GCF-1, Claim Summary

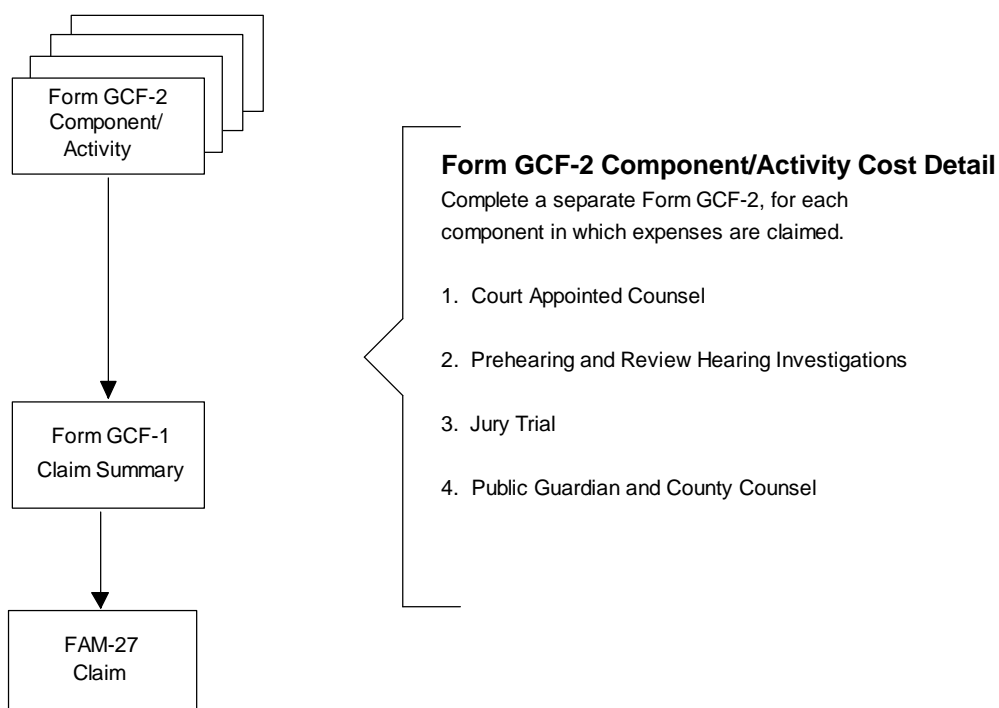
This form is used to summarize direct costs by component and compute allowable indirect costs for the mandate. The direct costs summarized on this form are derived from forms GCF-2 and are carried forward to FAM-27.

Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have its own ICRP.

C. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the county. All applicable information from form GCF-1 must be carried forward to this form in order for the State Controller's Office to process the claim for payment.

ILLUSTRATION OF CLAIM FORMS



CLAIM FOR PAYMENT Pursuant to Government Code Section 17561 GUARDIANSHIP AND CONSERVATORSHIP FILINGS			For State Controller Use Only	
(01) Claimant Identification Number			(19) Program Number 00027	
(02) Mailing Address			(20) Date File _____/_____/_____	
Claimant Name			(21) LRS Input _____/_____/_____	
County of Location			(22) GCF-1, (03)(1)	
Street Address or P. O. Box			(23) GCF-1, (03)(2)	
City State Zip Code			(24) GCF-1, (03)(3)	
			(25) GCF-1, (03)(4)	
			(26) GCF-1, (03)(5)	
Type of Claim			Reimbursement Claim Data	
(03) Estimated <input type="checkbox"/>			(27) GCF-1, (04)(1)	
(04) Combined <input type="checkbox"/>			(28) GCF-1, (04)(2)	
(05) Amended <input type="checkbox"/>			(29) GCF-1, (04)(3)	
(09) Reimbursement <input type="checkbox"/>			(30) GCF-1, (04)(4)	
(10) Combined <input type="checkbox"/>			(31) GCF-1, (06)	
(11) Amended <input type="checkbox"/>				
Fiscal Year of Cost				
(06) _____			(12) 7/1/97 to 8/16/97	
Total Claimed			(13) _____	
(07) _____			(32) _____	
Less: 10% Late Penalty, not to exceed \$1000			(14) _____	
(15) _____			(33) _____	
Less: Estimated Claim Payment Received			(34) _____	
(16) _____			(35) _____	
Net Claimed Amount			(36) _____	
(17) _____			(37) _____	
Due from State			(18) _____	
(08) _____				
Due to State				
(38) CERTIFICATION OF CLAIM <p>In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1357, Statutes of 1976; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.</p> <p>I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1357, Statutes of 1976.</p> <p>The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1357, Statutes of 1976, set forth on the attached statements.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%;"> <p>Signature of Authorized Representative</p> <p>_____</p> <p>Type or Print Name</p> <p>_____</p> </div> <div style="width: 45%;"> <p>Date</p> <p>_____</p> <p>Title</p> <p>_____</p> </div> </div>				
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>(39) Name of Contact Person for Claim</p> <p>_____</p> </div> <div style="width: 45%;"> <p>Telephone Number</p> <p>(____) _____ Ext. _____</p> </div> </div>				

GUARDIANSHIP AND CONSERVATORSHIP FILINGS**Certification Claim Form****Instructions****FORM
FAM-27**

- (01) Leave blank.
- (02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the place shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.
- (03) to (08) Leave blank.
- (09) If filing a reimbursement claim, enter an "X" in the box on line (09) Reimbursement.
- (10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.
- (11) If filing an amended claim, enter an "X" in the box on line (11) Amended.
- (12) No entry required.
- (13) Enter the amount of reimbursement claim from form GCF-1, line (11).
- (14) If a reimbursement claim is filed after **June 25, 1999**, the claim must be reduced by a late penalty. Enter the product of multiplying line (13) by the factor 0.10 (10% penalty) or \$1,000, whichever is less.
- (15) No entry required.
- (16) Enter the result of subtracting line (14) from line (13).
- (17) Enter the amount from line (16) on line (17), Due from State.
- (18) to (21) Leave blank.
- (22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (31) for the reimbursement claim [e.g., GCF-1, (03)(1), means the information is located on form GCF-1, line (03), column (1). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect cost percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35).
- (38) Read the statement "Certification of Claim." If the statement is true, the claim must be dated, signed by the agency's authorized representative and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.
- (39) Enter the name of the person and telephone number that this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

***Address, if delivered by
U.S. Postal Service:***

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250**

***Address, if delivered by
other delivery service:***

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816**

MANDATED COSTS GUARDIANSHIP AND CONSERVATORSHIP FILINGS CLAIM SUMMARY				FORM GCF-1
(01) Claimant		(02) Type of Claim Reimbursement Claimable Period of Costs 7/1/97 to 8/16/97		
Claim Statistics				
(03) For the claim period 7/1/97 to 8/16/97, enter:				
1. Number of court investigator interviews made pursuant to Probate Code Section 1826 and 1850 (adult persons).				
2. Number of cases where the court appointed a public defender or other attorney to represent the person in a guardianship or conservatorship hearing.				
3. Number of cases where a private conservatorship was terminated and the case was reassigned to a public guardian.				
4. Number of court investigator interviews made pursuant to Probate Code Section 2253 (minors).				
5. Number of jury trials.				
Direct Costs		Object Accounts		
(04) Reimbursable Components		(a) Salaries	(b) Benefits	(c) Services and Supplies
1. Court Appointed Counsel				(d) Total
2. Pre-hearing and Review Hearing Investigations				
3. Jury Trial				
4. Public Guardian and County Counsel				
(05) Total Direct Costs				
Indirect Costs				
(06) Indirect Cost Rate [From ICRP]				%
(07) Total Indirect Costs [Line (06) x line (05)(a)] or [line (06) x {line (05)(a) + line (05)(b)}]				
(08) Total Direct and Indirect Costs [Line (05)(d) + line (07)]				
Cost Reduction				
(09) Less: Offsetting Savings, if applicable				
(10) Less: Other Reimbursements, if applicable				
(11) Total Claimed Amount [Line (08) - {Line (09) + Line (10)}]				

GUARDIANSHIP AND CONSERVATORSHIP FILINGS
CLAIM SUMMARY
Instructions

FORM
GCF-1

- (01) Enter the name of the claimant.
- (02) Type of Claim. No entry required.
- (03) For the claim period 7/1/97 to 8/16/97, enter:
1. Number of court investigator interviews made pursuant to Probate Code Section 1826 and 1850 (adult persons).
 2. Number of cases where the court appointed a public defender or other attorney to represent the person in a guardianship or conservatorship hearing.
 3. Number of cases where private conservatorship was terminated and the case was reassigned to a public guardian.
 4. Number of court investigator interviews made pursuant to Probate Code Section 2253 (minors).
 5. Number of jury trials.
- (04) Reimbursable Components. For each reimbursable component enter the total from form GCF-2, line (06), columns (d), (e), and (f) to form GCF-1, block (04) columns (a), (b), and (c) in the appropriate row. Total each row.
- (05) Total columns (a) through (d).
- (06) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have their own ICRP.
- (07) Total Indirect Costs. Multiply Total Salaries, line (05)(a), by the Indirect Cost Rate, line (06). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (05)(a), and Total Benefits, line (05)(b), by the Indirect Cost Rate, line (06).
- (08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(d), and Total Indirect Costs, line (07).
- (09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.
- (10) Less: Other Reimbursements, if applicable. Any offsetting savings or reimbursement the claimant received from any source including but not limited to, service fees collected, federal funds, and other state funds as a result of this mandate, shall be identified and deducted so only the net local cost is claimed.
- (11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10), from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (13), for the Reimbursement Claim.

MANDATED COSTS GUARDIAN AND CONSERVATION FILINGS COMPONENT/ACTIVITY COST DETAIL					FORM GCF-2
(01) Claimant			(02) Claimable Period of Costs 7/1/97 to 8/16/97		
(03) Reimbursable Component: Check only one box per form to identify the component being claimed.					
<input type="checkbox"/> Prehearing and Review Hearing Investigations		<input type="checkbox"/> Court Appointed Counsel			
<input type="checkbox"/> Public Guardian and County Counsel		<input type="checkbox"/> Jury Trial			
(04) Description of Expenses: Complete columns (a) through (f).				Object Accounts	
(a)	(b)	(c)	(d)	(e)	(f)
Employee Names, Job Classifications, Functions Performed and Description of Services and Supplies	Hourly Rate or Unit cost	Hours Worked or Quantity	Salaries	Benefits	Services and Supplies
(05) Total <input style="width: 50px;" type="text"/> Subtotal <input style="width: 50px;" type="text"/> Page: _____ of _____					

GUARDIAN AND CONSERVATORSHIP FILINGS
COMPONENT/ACTIVITY COST DETAIL
Instructions

FORM
GCF-2

- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form GCF-2 shall be prepared for each component which applies.
- (04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, and contracted services. Do not claim any costs related to "Court Operations" if the county has opted for the Trial Court Funding Program. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits	Title						
	Activities Performed	Benefit Rate	Hours Worked		Benefits = Benefit Rate x Salaries		
Services and Supplies							
Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Used	
Contracted Services	Name of Contractor	Hourly Rate	Hours Worked Inclusive Dates of Service			Itemized Cost of Services Performed	Invoice
Jury Expense	Juror Name Case Number	Daily Rate	Number of Days			Total Jury Expense Claimed	

- (05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component costs, number each page. Enter totals from line (05), columns (d), (e), and (f) to form GCF-1, block (04) columns (a), (b), and (c) in the appropriate row.

FILIPINO EMPLOYEE SURVEY

1. Summary of Chapter 845/78

Section 50087 of the Government Code, as added by Chapter 845, Statutes of 1978, requires cities and counties to categorize, in certain instances, Filipino employees as a separate ethnic classification in employee ethnicity surveys and tabulations.

On May 21, 1980, the Commission on State Mandates determined that the requirements of Section 50087 of the Government Code imposed upon cities and counties a new program or higher level of service within the meaning of Section 6, Article XIII B of the California Constitution and Section 17514 of the Government Code.

2. Eligible Claimants

Any city, city and county, or county with a population of at least 5,000 residents or in which five percent of the population is of Filipino ancestry or ethnic origin, according to the last federal census, and which conducts a survey of the ancestry or ethnic origin of its employees or maintains any statistical tabulation of minority group employees is eligible for claim reimbursement of increased costs incurred as a result of complying with this mandate.

3. Reimbursable Component

Eligible claimants will be reimbursed for increased costs incurred during the period of 7/1/97 through 8/16/97 as a direct result of a survey of employees to determine how many were of Filipino ancestry or ethnic origin in the work force.

A. Collection and Tabulation of Survey Results

The incremental cost of salaries and benefits associated with personnel directly assigned to the collection and tabulation of data that was collected during the Filipino employee survey is reimbursable.

Claimants have the option of:

- (1) Claiming the actual increased costs of collection and tabulation of data for the Filipino survey or;
- (2) Claiming reimbursement of the collection and tabulation costs based on the percent of Filipino employees in the work force.

4. Reimbursement Limitations

Any offsetting savings or reimbursement the claimant received from any source including but not limited to, service fees collected, federal funds, and other state funds, as a direct result of this mandate, shall be identified and deducted so only the net local cost is claimed.

5. Claiming Forms and Instructions

The diagram entitled, "Illustration of Claim Forms", provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for form FES-1 and form FES-2, provided the format of the report and data fields contained within the report are identical to the claim forms included in this chapter.

The claim forms provided in this chapter can be duplicated and used by the claimant to file a reimbursement claim.

A. Form FES-2, Component/Activity Cost Detail

This form is used to segregate the detailed costs by claim component. A separate form FES-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed and specify the actual time devoted to each function by each employee, productive hourly rate, and related fringe benefits.

Reimbursement for personal services include compensation paid for salaries, wages, and employee fringe benefits. Employee fringe benefits include regular compensation paid to an employee during periods of authorized absences (e.g., annual leave, sick leave) and the employer's contribution of social security, pension plans, insurance, and worker's compensation insurance. Fringe benefits are eligible for reimbursement when distributed equitably to all job activities which the employee performs.

Source documents may include, but are not limited to, time logs evidencing actual costs claimed under Reimbursable Activities, time sheets, payroll records, canceled payroll warrants, organization charts, duty statements, pay rate schedules, and other documents evidencing the expenditure.

(2) Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of the materials and supplies consumed specifically for the purposes of this mandate. Purchases shall be claimed at the actual price after deducting cash discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged based on a recognized method of costing, consistently applied.

Source documents may include, but are not limited to, general and subsidiary ledgers, invoices, purchase orders, receipts, canceled warrants, inventory records, and other documents evidencing the expenditure.

(3) Contract Services

Provide the name(s) of the contractor(s) who performed the services, including any fixed contracts for services. Describe the reimbursable activity(ies) performed by each named contractor and give the number of actual hours spent on the activities, if applicable. Show the inclusive dates when services were performed and itemize all costs for those services. Attach consultant invoices with the claim.

Source documents may include, but are not limited to, general and subsidiary ledgers, contracts, invoices, canceled warrants, and other documents evidencing the validity of the expenditure.

For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the

reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

B. Form FES-1, Claim Summary

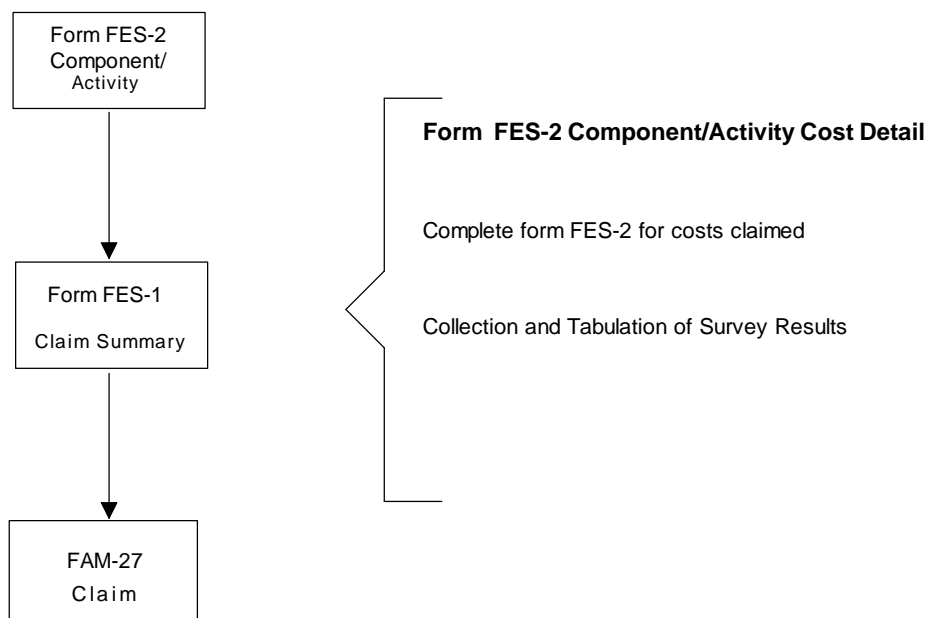
This form is used to summarize direct costs and compute allowable indirect costs for the mandate. The direct costs summarized on this form are derived from form FES-2 and carried forward to FAM-27.

Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits, as long as the direct labor costs are directly related to the cost of performing the mandate. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have its own ICRP.

C. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the city or county. All applicable information from form FES-1 must be carried forward to this form in order for the State Controller's Office to process the claim for payment.

Illustration of Claim Forms



CLAIM FOR PAYMENT Pursuant to Government Code Section 17561 FILIPINO EMPLOYEE SURVEY			For State Controller Use Only	
(01) Claimant Identification Number			(19) Program Number 00021	
(02) Mailing Address			(20) Date File _____/_____/_____	
Claimant Name			(21) LRS Input _____/_____/_____	
L A B E L H E R E	County of Location		Reimbursement Claim Data	
	Street Address or P. O. Box		(22) FES-1, (03)(a)	
	City State Zip Code		(23) FES-1, (04)(1)(d)	
			(24) FES-1, (05)	
			(25)	
Type of Claim		Estimated Claim	Reimbursement Claim	(26)
(03) Estimated <input type="checkbox"/>		(09) Reimbursement <input type="checkbox"/>	(27)	
(04) Combined <input type="checkbox"/>		(10) Combined <input type="checkbox"/>	(28)	
(05) Amended <input type="checkbox"/>		(11) Amended <input type="checkbox"/>	(29)	
			(30)	
Fiscal Year of Cost		(06)	(12) 7/1/97 to 8/16/97	(31)
Total Claimed		(07)	(13)	(32)
Less: 10% Late Penalty, not to exceed \$1000			(14)	(33)
Less: Estimated Claim Payment Received			(15)	(34)
Net Claimed Amount			(16)	(35)
Due from State		(08)	(17)	(36)
Due to State			(18)	(37)
(38) CERTIFICATION OF CLAIM <p>In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 845, Statutes of 1978; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.</p> <p>I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 845, Statutes of 1978.</p> <p>The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 845, Statutes of 1978, set forth on the attached statements.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div>Signature of Authorized Representative</div> <div>Date</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div>_____</div> <div>_____</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div>Type or Print Name</div> <div>Title</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div>_____</div> <div>_____</div> </div>				
(39) Name of Contact Person for Claim			Telephone Number	
_____			(____) _____ Ext. _____	

FILIPINO EMPLOYEE SURVEY**Certification Claim Form****Instructions****FORM
FAM-27**

- (01) Leave blank.
- (02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the place shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.
- (03) to (8) Leave blank.
- (09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.
- (10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.
- (11) If filing an amended claim, enter an "X" in the box on line (11) Amended.
- (12) No entry required.
- (13) Enter the amount of reimbursement claim from form FES-1, line (10).
- (14) If a reimbursement claim is filed after **June 25, 1999**, the claim must be reduced by a late penalty. Enter the product of multiplying line (13) by the factor 0.10 (10% penalty) or \$1,000, whichever is less.
- (15) No entry required.
- (16) Enter the result of subtracting line (14) from line (13).
- (17) Enter the amount from line (16) on line (17), Due from State.
- (18) to (21) Leave blank.
- (22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (24) for the reimbursement claim [e.g., FES-1, (03)(a), means the information is located on form FES-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect cost percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35).
- (38) Read the statement "Certification of Claim." If the statement is true, the claim must be dated, signed by the agency's authorized representative and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.
- (39) Enter the name of the person and telephone number that this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

***Address, if delivered by:
U.S. Postal Service***

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250**

***Address, if delivered by:
Other delivery service***

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816**

MANDATED COSTS FILIPINO EMPLOYEE SURVEY CLAIM SUMMARY				FORM FES-1	
(01) Claimant			(02) Type of Claim Reimbursement		
			Claimable Period for Costs: 7/1/97 to 8/16/97		
Claim Statistics					
(03) a. Number of Filipino employees in the work force.					
b. Number of employees in the work force.					
c. Percent of Filipino employees, if applicable. [line (03)(a) ÷ line (03)(b)]					
Direct Costs			Object Accounts		
(04) Reimbursable Components:			(a)	(b)	(c)
			Salaries	Benefits	Services and Supplies
Collection and tabulation of survey results					
Indirect Costs					
(05) Indirect Cost Rate [From ICRP]					%
(06) Total Indirect Costs [Line (05) x line (04)(a)] or [line (05) x {line (04)(a) + line (04)(b)}]					
(07) Total Direct and Indirect Costs [Line (04)(d) + line (06)]					
Cost Reduction					
(08) Less: Offsetting Savings, if applicable					
(09) Less: Other Reimbursements, if applicable					
(10) Total Claim, see instructions: <input type="checkbox"/> Incremental Cost <input type="checkbox"/> Percent Filipino Employee					

**FILIPINO EMPLOYEE SURVEY
CLAIM SUMMARY
Instructions**

**FORM
FES-1**

- (01) Enter the name of the claimant.
- (02) Type of Claim. No entry required.
- (03) a. Enter the number of Filipino employees.
b. Enter the number of employees.
c. Divide number of Filipino employees, line (03)(a) by the number of employees, line (03)(b).
- (04) Reimbursable Components. Enter the total from form FES-2, line (05) columns (d) and (e) and enter the sum in column (d).
- (05) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have their own ICRP.
- (06) Total Indirect Costs. Multiply Total Salaries, line (04)(a), by the Indirect Cost Rate, line (05). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (04)(a), and Total Benefits, line (04)(b), by the Indirect Cost Rate, line (05).
- (07) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (04)(d), and Total Indirect Costs, line (06).
- (08) Enter total savings experienced by the claimant as a direct result of this mandate. Submit a schedule of detailed savings with the claim.
- (09) Enter total other reimbursements received from any source, (i.e., federal, other State programs, etc.). Submit a schedule of detail reimbursements with the claim.
- (10) Mark box to indicate method selected:

INCREMENTAL COST : Subtract the sum of Offsetting Savings, line (08), and Other Reimbursements, line (09), from Total Direct and Indirect Costs, line (07). Enter the remainder on this line and carry forward to form FAM-27, line (13) for the Reimbursement claim.

PERCENT FILIPINO EMPLOYEES : Subtract the sum of Offsetting Savings, line (08), and Other Reimbursements, line (09), from Total Direct and Indirect Costs, line (07), and multiply by Percent of Filipino employees in the work force, line (03)(a). Enter the remainder on this line and carry forward to form FAM-27, line (13) for the Reimbursement claim.

MANDATED COSTS FILIPINO EMPLOYEE SURVEY COMPONENT/ACTIVITY COST DETAIL					FORM FES-2
(01) Claimant			(02) Claimable Period of Costs: 7/1/97 to 8/16/97		
(03) Reimbursable Component: Collection and Tabulation of Survey Reports					
(04) Description of Expenses: Complete columns (a) through (f).				Object Accounts	
(a)	(b)	(c)	(d)	(e)	(f)
Employee Names, Job Classifications, Functions Performed and Description of Services and Supplies	Hourly Rate or Unit cost	Hours Worked or Quantity	Salaries	Benefits	Services and Supplies
(05) Total <input style="width: 50px;" type="text"/> Subtotal <input style="width: 50px;" type="text"/> Page: _____ of _____					

**FILIPINO EMPLOYEE SURVEY
COMPONENT/ACTIVITY COST DETAIL
Instructions**

**FORM
FES-2**

NOTE: The claimant has the option of using one of the following methods to compute reimbursable cost:

A. Incremental Cost: Report only the actual incremental increased costs of collection and tabulation of survey, or

B. Percent Filipino Employee: Report the total cost of collection and tabulation of all ethnic surveys and multiply by the number of Filipino employees in the work force.

- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Reimbursable Components. Collection and Tabulation of Survey Reports. A separate form FES-2 shall be prepared for each component which applies.
- (04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs of collecting and tabulating data associated with the survey of Filipino employees, enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, and contracted services. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits	Title Activities	Benefit Rate	Hours Worked		Benefits = Benefit Rate x Salaries		
Services and Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Used	
Contract Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service			Itemized Cost of Services Performed	Invoice

- (05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component costs, number each page. Enter totals from line (05), columns (d), (e), and (f) to form FES-1, block (04) columns (a), (b), and (c) in the appropriate row.

HANDICAPPED VOTER ACCESSIBILITY

1. Summary of Chapter 494/79

Elections Code Sections 1638.5 and 10010.2 as added by Chapter 494, Statutes of 1979, and renumbered as Sections 12280 and 13304 respectively by Chapter 920, Statutes of 1994, require polling places to be accessible to the physically handicapped and voters to be informed whether polling places are accessible to the physically handicapped and of their right to assistance in marking the ballot.

On June 18, 1980, the Commission on State Mandates (former Board of Control) determined that the requirements of Elections Code Sections 1638.5 and 10010.2 imposed upon counties a new program or higher level of service within the meaning of Section 6, Article XIII B of the California Constitution and Section 17514 of the Government Code.

2. Eligible Claimants

Any county that incurred increased costs as a direct result of this mandate is eligible to claim reimbursement of these costs.

3. Reimbursable Components

Eligible claimants will be reimbursed for costs incurred during the period 7/1/97 through 8/16/97 for the following activities:

A. Survey of New Polling Places

The cost of surveying newly selected polling places for accessibility to handicapped voters is reimbursable.

B. Resolution of Complaints

The cost of resolving complaints received by the county concerning accessibility of polling places to handicapped voters is reimbursable.

4. Reimbursement Limitation

Any offsetting savings or reimbursement the claimant received from any source including but not limited to, service fees collected, federal funds, and other state funds as a result of this mandate, shall be identified and deducted so only the net local cost is claimed.

5. Claiming Forms and Instructions

The diagram, "Illustration of Claim Forms," provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for forms HVA-1 and HVA-2 provided the format of the report and data fields contained within the report are identical to the claim forms included in these instructions. The claim forms provided with these instructions should be duplicated and used by the claimant to file reimbursement claims.

A. Form HVA-2, Component Claim Summary

This form is used to segregate the detailed costs by claim component. A separate form HVA-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed and specify the actual time devoted to each function by each employee, productive hourly rate, and related fringe benefits.

Reimbursement for personal services includes compensation paid for salaries, wages, and employee fringe benefits. Employee fringe benefits include regular compensation paid to an employee during periods of authorized absences (e.g., annual leave, sick leave) and the employer's contribution of social security, pension plans, insurance, and worker's compensation insurance. Fringe benefits are eligible for reimbursement when distributed equitably to all job activities which the employee performs.

Source documents may include, but are not limited to, time logs evidencing actual costs claimed under Reimbursable Activities, time sheets, payroll records, canceled payroll warrants, organization charts, duty statements, pay rate schedules, and other documents evidencing the expenditure.

(2) Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of the materials and supplies consumed specifically for the purposes of this mandate. Purchases shall be claimed at the actual price after deducting cash discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged based on a recognized method of costing, consistently applied.

Source documents may include, but are not limited to, general and subsidiary ledgers, invoices, purchase orders, receipts, canceled warrants, inventory records, and other documents evidencing the expenditure.

(3) Contract Services

Provide the name(s) of the contractor(s) who performed the services, including any fixed contracts for services. Describe the reimbursable activity(ies) performed by each named contractor and give the number of actual hours spent on the activities, if applicable. Show the inclusive dates when services were performed and itemize all costs for those services. Attach consultant invoices with the claim.

Source documents may include, but are not limited to, general and subsidiary ledgers, contracts, invoices, canceled warrants, and other documents evidencing the validity of the expenditure.

(4) Travel

Travel expenses for mileage, per diem, lodging and other employee entitlements are reimbursable in accordance with the rules of the local jurisdiction. Give the

name(s) of the traveler(s), purpose of travel, inclusive travel dates, destination points, and costs.

Source documents to be maintained by the claimant may include, but are not limited to, receipts, employee travel expense claims, and other documents evidencing the validity of the expenditures.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

B. Form HVA-1, Claim Summary

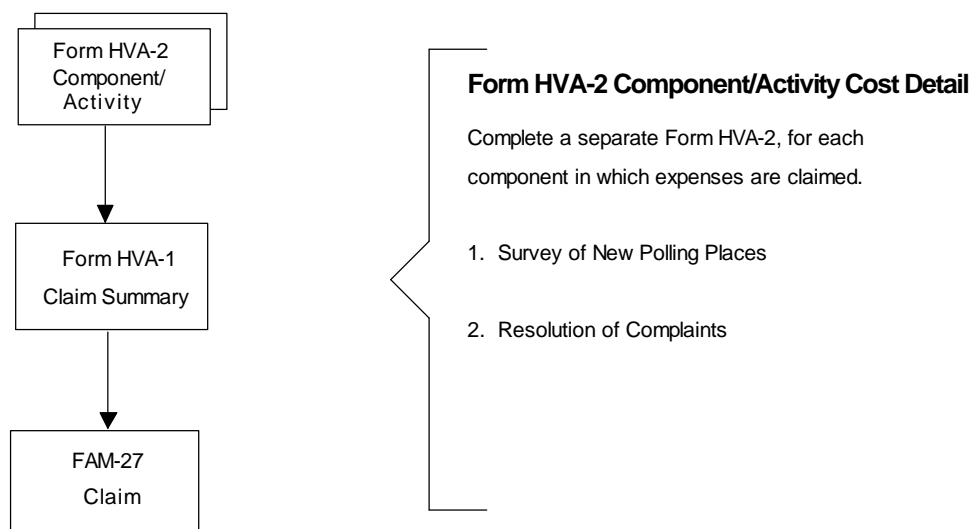
This form is used to summarize direct costs and compute allowable indirect costs for the mandate. The direct costs summarized on this form are derived from form HVA-2 and are carried forward to FAM-27.

Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits, as long as the direct labor costs are directly related to the cost of performing the mandate. If an indirect cost rate greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have its own ICRP.

C. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the county. All applicable information from form HVA-1 must be carried forward in order for the State Controller's Office to process the claim for payment.

Illustration of Claim Forms



CLAIM FOR PAYMENT Pursuant to Government Code Section 17561 HANDICAPPED VOTER ACCESSIBILITY			For State Controller Use Only	
			(19) Program Number 00028	
			(20) Date File _____/_____/_____	
			(21) LRS Input _____/_____/_____	
L A B E L H E R E	(01) Claimant Identification Number		Reimbursement Claim Data	
	(02) Mailing Address		(22) HVA-1, (03)(1)	
	Claimant Name		(23) HVA-1, (03)(2)	
	County of Location		(24) HVA-1, (04)(1)(e)	
	Street Address or P. O. Box		(25) HVA-1, (04)(2)(e)	
	City _____ State _____ Zip Code _____		(26) HVA-1, (06)	
			(27) HVA-1, (11)	
Type of Claim	Estimated Claim	Reimbursement Claim		
(03) Estimated <input type="checkbox"/>	(09) Reimbursement <input type="checkbox"/>	(28)		
(04) Combined <input type="checkbox"/>	(10) Combined <input type="checkbox"/>	(29)		
(05) Amended <input type="checkbox"/>	(11) Amended <input type="checkbox"/>	(30)		
Fiscal Year of Cost	(06)	(12) 7/1/97 to 8/16/97	(31)	
Total Claimed	(07)	(13)	(32)	
Less: 10% Late Penalty, not to exceed \$1000		(14)	(33)	
Less: Estimated Claim Payment Received		(15)	(34)	
Net Claimed Amount		(16)	(35)	
Due from State	(08)	(17)	(36)	
Due to State		(18)	(37)	
(38) CERTIFICATION OF CLAIM				
<p>In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 494, Statutes of 1979; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.</p> <p>I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 494, Statutes of 1979.</p> <p>The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 494, Statutes of 1979, set forth on the attached statements.</p>				
Signature of Authorized Representative		Date		
_____		_____		
Type or Print Name		Title		
_____		_____		
(39) Name of Contact Person for Claim		Telephone Number		
_____		(_____) _____ Ext. _____		

HANDICAPPED VOTER ACCESSIBILITY Certification Claim Form Instructions	FORM FAM-27
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- (01) Leave blank.
- (02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the place shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.
- (03) to (08) Leave blank.
- (09) If filing a reimbursement claim, enter an "X" in the box on line (09) Reimbursement.
- (10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.
- (11) If filing an amended claim, enter an "X " in the box on line (11) Amended.
- (12) No entry required.
- (13) Enter the amount of reimbursement claim from form HVA-1, line (11).
- (14) If a reimbursement claim is filed after **June 25, 1999**, the claim must be reduced by a late penalty. Enter the product of multiplying line (13) by the factor 0.10 (10% penalty) or \$1,000, whichever is less.
- (15) No entry required.
- (16) Enter the result of subtracting line (14) from line (13).
- (17) Enter the amount from line (16) on line (17), Due from State.
- (18) to (21) Leave blank.
- (22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (27) for the reimbursement claim [e.g., HVA-1, (03)(1), means the information is located on form HVA-1, line (03), column (1). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect cost percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35).
- (38) Read the statement "Certification of Claim." If the statement is true, the claim must be dated, signed by the agency's authorized representative and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.
- (39) Enter the name of the person and telephone number that this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

***Address, if delivered by
U.S. Postal Service:***

***Address, if delivered by
other delivery service:***

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250**

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816**

MANDATED COSTS HANDICAPPED VOTER ACCESSIBILITY CLAIM SUMMARY					FORM HVA-1
(01) Claimant		(02) Type of Claim Reimbursement			
		Claimable Period of Costs 7/1/97 to 8/16/97			
Claim Statistics					
(03) 1. Number of complaints investigated and/or resolved (during the period 7/1/97 to 8/16/97)					
2. Number of new polling places surveyed for handicapped voter accessibility (during the period 7/1/97 to 8/16/97)					
Direct Costs		Object Accounts			
(04) Reimbursable Components	(a) Salaries	(b) Benefits	(c) Services and Supplies	(d) Travel	(e) Total
1. Survey of New Polling Places					
2. Resolution of Complaints					
(05) Total Direct Costs					
Indirect Costs					
(06) Indirect Cost Rate [From ICRP]					%
(07) Total Indirect Costs [Line (06) x line (05)(a)] or [line (06) x {line (05)(a) + line (05)(b)}]					
(08) Total Direct and Indirect Costs: [Line (05)(e) + line (07)]					
Cost Reduction					
(09) Less: Offsetting Savings, if applicable					
(10) Less: Other Reimbursements, if applicable					
(11) Total Claimed Amount [Line (08) - {Line (09) + Line (10)}]					

HANDICAPPED VOTER ACCESSIBILITY CLAIM SUMMARY Instructions	FORM HVA-1
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- (01) Enter the name of the claimant.
- (02) Type of Claim. No entry required.
- (03) 1. Enter the number of complaints regarding handicapped voter accessibility that were investigated and/or resolved during the period 7/1/97 to 8/16/97.
2. Enter number of new polling places surveyed for handicapped voter accessibility during the period 7/1/97 to 8/16/97.
- (04) Reimbursable Components. For each reimbursable component enter the total from form HVA-2, line (05), columns (d), (e), (f), and (g) to form HVA-1, block (04) columns (a), (b), (c), and (d) in the appropriate row. Total each row.
- (05) Total Direct Costs. Total columns (a) through (e).
- (06) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have their own ICRP.
- (07) Total Indirect Costs. Multiply Total Salaries, line (05)(a), by the Indirect Cost Rate, line (06). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (05)(a), and Total Benefits, line (05)(b), by the Indirect Cost Rate, line (06).
- (08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(e), and Total Indirect Costs, line (07).
- (09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.
- (10) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source, including but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.
- (11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements line (10), from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (13) for the Reimbursement Claim.

MANDATED COSTS HANDICAPPED VOTER ACCESSIBILITY COMPONENT/ACTIVITY COST DETAIL					FORM HVA-2	
(01) Claimant			(02) Claimable Period of Costs 7/1/97 to 8/16/97			
(03) Reimbursable Component: Check only one box per form to identify the component being claimed. <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <input type="checkbox"/> Survey of New Polling Places <input type="checkbox"/> Resolution of Complaints </div>						
(04) Description of Expenses: Complete columns (a) through (g).			Object Accounts			
(a) Employee Names, Job Classifications, Functions Performed and Description of Services and Supplies	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Services and Supplies	(g) Travel
(05) Total <input style="width: 50px;" type="text"/> Subtotal <input style="width: 50px;" type="text"/> Page: _____ of _____						

HANDICAPPED VOTER ACCESSIBILITY COMPONENT/ACTIVITY COST DETAIL Instructions	FORM HVA-2
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- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form HVA-2 shall be prepared for each component which applies.
- (04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contract services and travel expenses. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns						(g)	Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)		
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked				
Benefits	Title							
	Activities Performed	Benefit Rate	Hours Worked		Benefits = Benefit Rate x Salaries			
Services and Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Used		
Contract Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service			Itemized Cost of Services Performed		Invoice
Travel	Purpose of Trip Name and Title	Per Diem Rate	Days				Rate x Days or Miles	
	Departure and Return Date	Mileage Rate	Miles				Total Travel Cost	
		Travel Cost	Travel Mode					

- (05) Total line (04), columns (d), (e), (f), and (g) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component costs, number each page. Enter totals from line (05), columns (d), (e), (f), and (g) to form HVA-1, block (04) columns (a), (b), (c), and (d) in the appropriate row.

DEAF TELETYPE EQUIPMENT

1. Summary of Chapter 1032/80

Government Code Section 23025 as added by Chapter 1032, Statutes of 1980, requires counties that provide emergency services to supply deaf teletype equipment (TTY) at the central location for police, fire fighting, and emergency medical services so that emergency services can be made available to the deaf community. Prior to the enactment of this chapter, counties were not required to provide TTY at a central location.

2. Eligible Claimants

Any county that has incurred increased costs as a direct result of this mandate is eligible to claim reimbursement of these costs.

3. Reimbursable Component

Eligible claimants will be reimbursed for costs incurred during the period 7/1/97 to 8/16/97 for rental of deaf teletype equipment.

4. Reimbursement Limitations

Any offsetting savings or reimbursement the claimant received from any source including, but not limited to, service fees collected, federal funds, and other state funds as a result of this mandate, shall be identified and deducted so only the net local cost is claimed.

5. Claiming Forms and Instructions

The diagram "Illustration of Claim Forms" provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for form DTE-1 provided the format of the report and data fields contained within the report are identical to the claim forms included in these instructions. The claim forms provided with these instructions should be duplicated and used by the claimant to file reimbursement claims.

A. Form DTE-1, Claim Summary

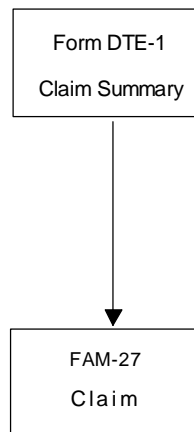
This form is used to summarize direct costs for rental of deaf teletype equipment.

Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have its own ICRP.

For audit purposes all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later.

B. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the county. All applicable information from form DTE-1 must be carried forward to this form in order for the State Controller's Office to process the claim for payment.

ILLUSTRATION OF CLAIM FORMS

CLAIM FOR PAYMENT Pursuant to Government Code Section 17561 DEAF TELETYPE EQUIPMENT			For State Controller Use Only	
(01) Claimant Identification Number			(19) Program Number 00062	
(02) Mailing Address			(20) Date File _____/_____/_____	
Claimant Name			(21) LRS Input _____/_____/_____	
County of Location			Reimbursement Claim Data	
Street Address or P. O. Box			(22) DTE-1, (03)	
City State Zip Code			(23) DTE-1, (05)	
			(24) DTE-1, (06)	
			(25)	
			(26)	
Type of Claim	Estimated Claim	Reimbursement Claim	(27)	
(03) Estimated <input type="checkbox"/>	(09) Reimbursement <input type="checkbox"/>		(28)	
(04) Combined <input type="checkbox"/>	(10) Combined <input type="checkbox"/>		(29)	
(05) Amended <input type="checkbox"/>	(11) Amended <input type="checkbox"/>		(30)	
Fiscal Year of Cost	(06)	(12) 7/1/97 to 8/16/97	(31)	
Total Claimed	(07)	(13)	(32)	
Less: 10% Late Penalty, not to exceed \$1000		(14)	(33)	
Less: Estimated Claim Payment Received		(15)	(34)	
Net Claimed Amount		(16)	(35)	
Due from State	(08)	(17)	(36)	
Due to State		(18)	(37)	
(38) CERTIFICATION OF CLAIM <p>In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1032, Statutes of 1980; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.</p> <p>I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1032, Statutes of 1980.</p> <p>The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1032, Statutes of 1980, set forth on the attached statements.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%;"> <p>Signature of Authorized Representative</p> <p>_____</p> <p>Type or Print Name</p> <p>_____</p> </div> <div style="width: 45%;"> <p>Date</p> <p>_____</p> <p>Title</p> <p>_____</p> </div> </div>				
(39) Name of Contact Person for Claim			Telephone Number	
_____			(____) _____ Ext. _____	

DEAF TELETYPE EQUIPMENT
Certification Claim Form
Instructions

FORM
FAM-27

- (01) Leave blank.
- (02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the place shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.
- (03) to (08) Leave blank.
- (09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.
- (10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.
- (11) If filing an amended claim, enter an "X " in the box on line (11) Amended.
- (12) No entry required.
- (13) Enter the amount of reimbursement claim from form DTE-1, line (10).
- (14) If a reimbursement claim is filed after **June 25, 1999**, the claim must be reduced by a late penalty. Enter the product of multiplying line (13) by the factor 0.10 (10% penalty) or \$1,000, whichever is less.
- (15) No entry required.
- (16) Enter the result of subtracting line (14) from line (13).
- (17) Enter the amount from line (16) on line (17), Due from State.
- (18) to (21) Leave blank.
- (22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (24) for the reimbursement claim [e.g., DTE-1, (03), means the information is located on form DTE-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents).
- (38) Read the statement "Certification of Claim." If the statement is true, the claim must be dated, signed by the agency's authorized representative and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.
- (39) Enter the name of the person and telephone number that this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

***Address, if delivered by:
U.S. Postal Service***

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250**

***Address, if delivered by:
other delivery service***

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816**

MANDATED COSTS DEAF TELETYPE EQUIPMENT CLAIM SUMMARY		FORM DTE-1
(01) Claimant	(02) Type of Claim: Reimbursement Claimable Period of Costs 7/1/97 to 8/16/97	
Rental of TTY		
(03) Monthly Rental Rate		
(04) Rental Cost	[(Line (03) x 1.516]	
(05) One-Time Equipment Charge		
(06) One-Time Installation Cost		
(07) Total Operating Costs of TTY	[Line (04) + line (05) + line (06)]	
Cost Reduction		
(08) Less: Offsetting Savings, if applicable		
(09) Less: Other Reimbursements, if applicable		
(10) Total Claimed Amount		

DEAF TELETYPE EQUIPMENT CLAIM SUMMARY Instructions	FORM DTE-1
---	-----------------------------

- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Enter the monthly rental rate. Attach a copy of the billing showing the monthly rental rate.
- (04) Multiply the Monthly Rental Rate, line (03), by the factor 1.516. Enter the product on this line.
- (05) Enter the one-time equipment charge associated with rental of the equipment.
- (06) Enter the installation charge associated with rental of the equipment if the equipment was installed during the period 7/1/97 to 8/16/97.
- (07) Enter the sum of Rental Cost, line (04), One-Time Equipment Charge, line (05), and One-Time Installation Cost, line (06).
- (08) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.
- (09) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.
- (10) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (08), and Other Reimbursements, line (09), from Total Operating Cost of TTY, line (07). Enter the difference on this line and carry the amount forward to form FAM-27, line (13) for the Reimbursement Claim.

NOTIFICATION OF INVOLUNTARY LIENS

1. Summary of Chapter 1281/80

Chapter 1281, Statutes of 1980, as added by Section 27297.5 and 27387 of the Government Code requires the county recorder to notify debtors of the recordation of involuntary liens affecting the title of real property. The county recorder collects a fee from the lienor for the recordation, except where the lienor is a governmental entity.

On October 21, 1981, the Board of Control, predecessor to the Commission on State Mandates, determined that these regulations resulted in state mandated costs that are reimbursable pursuant to Part 7 (commencing with Government Code Section 17500) of Division 4 of title 2.

2. Eligible Claimants

Any county that has incurred increased costs as a direct result of this mandate is eligible to claim reimbursement of these costs.

3. Reimbursable Components

Eligible claimants will be reimbursed for costs incurred during the period 7/1/97 to 8/16/97 for the following activities:

Counties will be reimbursed for increased costs associated with the recordation of involuntary liens and notification of judgment debtors in those cases where the lienor is a governmental entity (other than State of California or U.S. Government tax lienor). The amount of reimbursement per case is limited to the normal fee charged to a non-governmental lienor for this service.

4. Reimbursement Limitations

- A. The amount of reimbursement per case is limited to the normal fee charged to a non-governmental lienor for this service.
- B. Any offsetting savings or reimbursement the claimant received from any source including, but not limited to, service fees collected, federal funds, and other state funds as a direct result of this mandate, must be deducted from the amount claimed.

5. Claiming Forms and Instructions

The diagram entitled, "Illustration of Claim Forms," provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for form NIL-1, provided the format of the report and data fields contained within the report are identical to the claim forms included in this chapter. The claim forms provided in this chapter can be duplicated by the claimant to file a reimbursement claim.

A. Form NIL-1, Claim Summary

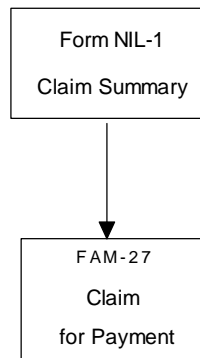
This form is used to summarize the number of involuntary liens filed by governmental entities and compute the notification fees that would have been collected if the lienor

had not been a governmental entity. The sum of the notification fees computed on this form are carried forward to FAM-27.

B. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the county. All applicable information from form NIL-1 must be carried forward to this form in order for the State Controller's Office to process the claim.

Illustration of Claim Forms



CLAIM FOR PAYMENT Pursuant to Government Code Section 17561 NOTIFICATION OF INVOLUNTARY LIENS			For State Controller Use Only	
			(19) Program Number 00132	
			(20) Date File _____/_____/_____	
			(21) LRS Input _____/_____/_____	
L A B E L H E R E	(01) Claimant Identification Number		Reimbursement Claim Data	
	(02) Mailing Address		(22) NIL-1, (04)	
	Claimant Name		(23)	
	County of Location		(24)	
	Street Address or P. O. Box		(25)	
	City State Zip Code		(26)	
Type of Claim	Estimated Claim	Reimbursement Claim	(27)	
(03) Estimated <input type="checkbox"/>	(09) Reimbursement <input type="checkbox"/>	(28)		
(04) Combined <input type="checkbox"/>	(10) Combined <input type="checkbox"/>	(29)		
(05) Amended <input type="checkbox"/>	(11) Amended <input type="checkbox"/>	(30)		
Fiscal Year of Cost	(06)	(12) 7/1/97 to 8/16/97	(31)	
Total Claimed	(07)	(13)	(32)	
Less: 10% Late Penalty, not to exceed \$1000		(14)	(33)	
Less: Estimated Claim Payment Received		(15)	(34)	
Net Claimed Amount		(16)	(35)	
Due from State	(08)	(17)	(36)	
Due to State		(18)	(37)	
<p>(38) CERTIFICATION OF CLAIM</p> <p>In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1281, Statutes of 1980; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.</p> <p>I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1281, Statutes of 1980.</p> <p>The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1281, Statutes of 1980, set forth on the attached statements.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%;"> <p>Signature of Authorized Representative</p> <p>_____</p> <p>Type or Print Name</p> </div> <div style="width: 45%;"> <p>Date</p> <p>_____</p> <p>Title</p> </div> </div>				
(39) Name of Contact Person for Claim			Telephone Number	
_____			(____) _____ Ext. _____	

NOTIFICATION OF INVOLUNTARY LIENS**Certification Claim Form****Instructions****FORM
FAM-27**

- (01) Leave blank.
- (02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the place shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.
- (03) to (08) Leave blank.
- (09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.
- (10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.
- (11) If filing an amended claim, enter an "X " in the box on line (11) Amended.
- (12) No entry required.
- (13) Enter the amount of reimbursement claim from form NIL-1, line (07). If more than one form NIL-1 is completed due to multiple department involvement in this mandate, add line (07) of each form NIL-1.
- (14) If a reimbursement claim is filed after **June 25, 1999**, the claim must be reduced by a late penalty. Enter the product of multiplying line (13) by the factor 0.10 (10% penalty) or \$1,000, whichever is less.
- (15) No entry required.
- (16) Enter the result of subtracting line (14) from line (13).
- (17) Enter the amount from line (16) on line (17), Due from State.
- (18) to (21) Leave blank.
- (22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (26) for the reimbursement claim [e.g., NIL-1, (04), means the information is located on form NIL-1, line (04)].
- (38) Read the statement "Certification of Claim." If the statement is true, the claim must be dated, signed by the agency's authorized representative and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.
- (39) Enter the name of the person and telephone number that this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

***Address, if delivered by:
U.S. Postal Service***

***Address, if delivered by:
Other delivery service***

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250**

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816**

MANDATED COSTS NOTIFICATION OF INVOLUNTARY LIENS CLAIM SUMMARY			FORM NIL-1
(01) Claimant: Department:		(02) Type of Claim: Reimbursement Claimable Period of Costs: 7/1/97 to 8/16/97	
Direct Costs			
(03)	(a) Name of Governmental Entity (Lienor)	(b) Number of Involuntary Liens	(c) Normal Fee
			(d) Claimable Amount
		\$	\$
(04) Total Direct Costs			
Cost Reduction			
(05) Less: Offsetting Savings, if applicable			
(06) Less: Other Reimbursements, if applicable			
(07) Total Claimed Amount			[Line (04) - {(Line (05) + Line (06))}]

<p style="text-align: center;">NOTIFICATION OF INVOLUNTARY LIENS CLAIM SUMMARY Instructions</p>	<p style="text-align: center;">FORM NIL-1</p>
--	---

- (01) Enter the name of the claimant.
- (02) Type of Claim. No entry required.
- (03) (a) List the names of Governmental Lienors
(b) Enter the number of liens for each governmental lienor.
(c) Enter the normal fee per lien foregone by the county.
(d) Multiply the Number of Liens, line (03)(b), by Normal Fee Per Lien, line (03)(c).
- (04) Total Direct Costs. Enter the sum of column (03)(d).
- (05) Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.
- (06) Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.
- (07) Subtract the sum of Offsetting Savings, line (05), and Other Reimbursements, line (06), from Total Direct Costs, line (04)(d). Enter the remainder on this line and carry the amount forward to form FAM-27.

VICTIMS' STATEMENTS - MINORS

1. Summary of Chapters 332/81 and 1425/84

Welfare and Institutions Code (WIC) Section 656.2, as added by Chapter 332, Statutes of 1981, and amended by Chapter 1425, Statutes of 1984, Chapter 569, Statutes of 1989, Chapter 324, Statutes of 1995, and Chapter 910, Statutes of 1997, requires that where there is a case in which a minor is alleged to have committed an act which would have been a felony if committed by an adult, the probation officer shall inform the victim of the rights of victims to submit a victim impact statement. If the victim exercises the right to submit a victim impact statement, the probation officer shall include in his or her study a statement from the victim concerning the offense and submit this to the Court pursuant to Section 706 of WIC. As added by Chapter 1616, Statutes of 1961, Section 706 of WIC relates to the Juvenile Court accepting into evidence a social study made by the probation officer and offered in any judgment or order of disposition.

Section 656.2 of the WIC was amended by Chapter 1425, Statutes of 1984, to add language to include a statement by the parent or guardian of the victim, if the victim is a minor, or in the event the victim has died, by the victim's next of kin. Further, Chapter 1425, Statutes of 1984, requires the probation officer to advise those persons giving statements as to the time and place of the disposition hearing.

On January 22, 1987, the Commission on State Mandates determined that Chapter 332, Statutes of 1981, and Chapter 1425, Statutes of 1984, imposed upon local agencies a new program or higher level of service, within the meaning of Section 6, Article XIII B of the California Constitution and Section 17514 of the Government Code.

2. Eligible Claimants

Any county that has incurred increased costs as a direct result of this mandate is eligible to claim reimbursement of costs.

3. Reimbursable Components

Eligible claimants will be reimbursed for the increased costs incurred during the period 7/1/97 through 8/16/97 to include a statement from the victim (or the parent or guardian of the victim under specified conditions) of a crime committed by a juvenile that would have been a felony if committed by an adult, and to advise those persons giving statements as to the time and place for the disposition hearing. Specifically, probation officer costs of the following activities are reimbursable.

- A. Informing the victim of the right to submit a victim impact statement. "Victim" is defined as the victim, parent or guardian of the victim if the victim is a minor, or, if the victim has died, the victim's next of kin.
- B. Including the victim's statement into the defendant's social study and submitting it to the court.
- C. Reviewing the victim's statement by the supervising probation officer.
- D. Informing the victim or the appropriate person giving statements as to the time and place of the disposition hearing.

4. Reimbursement Limitations

Any offsetting savings or reimbursement the claimant received from any source including, but not limited to, service fees collected, federal funds, and other state funds as a direct result of this mandate, shall be identified and deducted so only the net local cost is claimed.

5. Claim Forms and Instructions

The diagram "Illustration of Claim Forms" provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for form VSM-1 and form VSM-2, provided the format of the report and data fields contained within the report are identical to the claim forms included in these instructions. The claim forms provided with these instructions can be duplicated and used by the claimant to file reimbursement claims.

A. Form VSM-2, Component/Activity Cost Detail

This form is used to segregate the detailed costs by claim component. A separate form VSM-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed by each employee and specify the actual number of hours devoted to each function from 7/1/97 through 8/16/97, the productive hourly rate, and the related fringe benefits.

Reimbursement for personal services includes compensation paid for salaries, wages, and employee fringe benefits. Employee fringe benefits include regular compensation paid to an employee during periods of authorized absences (e.g., annual leave, sick leave) and the employer's contribution of social security, pension plans, insurance, and worker's compensation insurance. Fringe benefits are eligible for reimbursement when distributed equitably to all job activities which the employee performs.

Source documents may include, but are not limited to, time logs evidencing actual costs claimed under Reimbursable Activities, time sheets, payroll records, canceled payroll warrants, organization charts, duty statements, pay rate schedules, and other documents evidencing the expenditure.

(2) Supplies

Only expenditures that can be identified as a direct cost of the mandate can be claimed. List cost of materials that have been consumed or expended specifically for the purpose of this mandate from 7/1/97 through 8/16/97. Purchases shall be claimed at the actual price after deducting cash discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged based on a recognized method of costing, consistently applied.

Source documents may include, but are not limited to, general and subsidiary ledgers, invoices, purchase orders, receipts, canceled warrants, inventory records, and other documents evidencing the expenditure.

(3) Travel

Travel expenses incurred for the period 7/1/97 through 8/16/97 for mileage, per diem, lodging, and other employee entitlements are reimbursable in accordance with the rules of the local jurisdiction. Give the name(s) of the traveler(s), purpose of travel, inclusive travel dates, destination points, and costs.

Source documents to be maintained by the claimant may include, but are not limited to, receipts, employee travel expense claims, and other documents evidencing the validity of the expenditures.

For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

B. Form VSM-1, Claim Summary

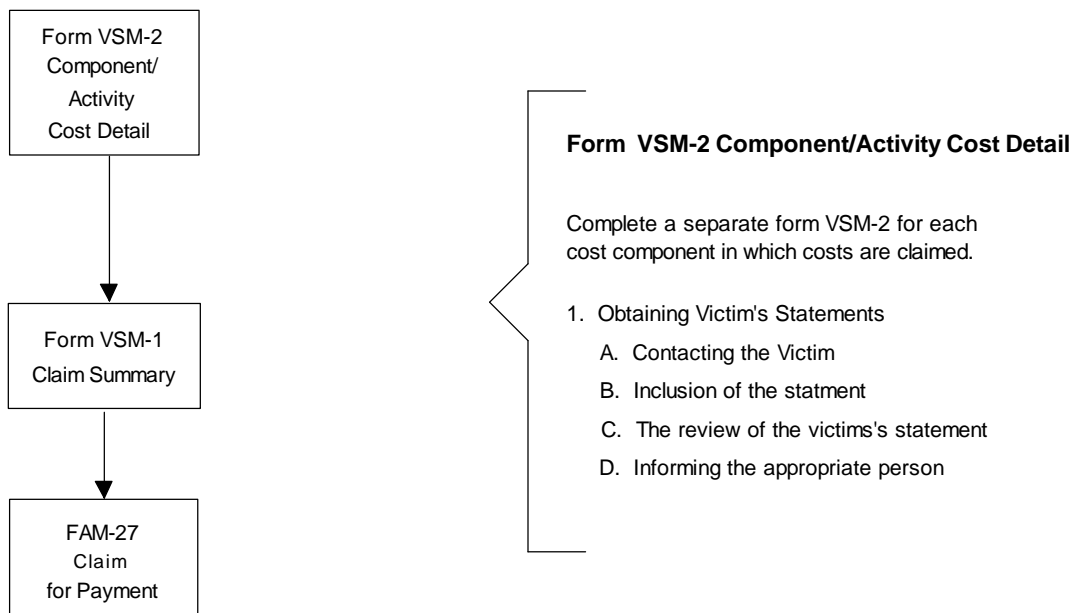
This form is used to summarize direct costs by component and compute allowable indirect costs for the mandate. The direct costs summarized on this form are derived from form VSM-2 and are carried forward to form FAM-27.

Indirect costs may be computed as 10% of direct costs, excluding fringe benefits. If an indirect cost rate greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have its own ICRP.

C. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the county. All applicable information from form VSM-1 must be carried forward to this form in order for the State Controller's Office to process the claim for payment.

Illustration of Claim Forms



CLAIM FOR PAYMENT Pursuant to Government Code Section 17561 VICTIMS' STATEMENTS - MINORS			For State Controller Use Only	
<div style="display: flex; align-items: center;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; margin-right: 5px;">LABEL HERE</div> <div> (01) Claimant Identification Number (02) Mailing Address Claimant Name County of Location Street Address or P. O. Box City State Zip Code </div> </div>			(19) Program Number 00071 (20) Date File _____/_____/_____ (21) LRS Input _____/_____/_____	
			Reimbursement Claim Data	
			(22) VSM-1, (03)(a)	
			(23) VSM-1, (08)(e)	
(24) VSM-1, (09)				
(25)				
(26)				
Type of Claim (03) Estimated <input type="checkbox"/> (04) Combined <input type="checkbox"/> (05) Amended <input type="checkbox"/>	Estimated Claim (06) <div style="background-color: #cccccc; height: 20px; width: 100%;"></div>	Reimbursement Claim (09) Reimbursement <input type="checkbox"/> (10) Combined <input type="checkbox"/> (11) Amended <input type="checkbox"/>	(27)	
			(28)	
			(29)	
			(30)	
Fiscal Year of Cost	(06)	(12) 7/1/97 to 8/16/97	(31)	
Total Claimed	(07)	(13)	(32)	
Less: 10% Late Penalty, not to exceed \$1000		(14)	(33)	
Less: Estimated Claim Payment Received		(15) <div style="background-color: #cccccc; height: 20px; width: 100%;"></div>	(34)	
Net Claimed Amount		(16)	(35)	
Due from State	(08) <div style="background-color: #cccccc; height: 20px; width: 100%;"></div>	(17)	(36)	
Due to State	<div style="background-color: #cccccc; height: 20px; width: 100%;"></div>	(18)	(37)	
(38) CERTIFICATION OF CLAIM <p>In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapters 332, Statutes of 1981 and Chapter 1425, Statutes of 1984; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.</p> <p>I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 332, Statutes of 1981 and Chapter 1425, Statutes of 1984.</p> <p>The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 332, Statutes of 1981 and Chapter 1425, Statutes of 1984, set forth on the attached statements.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%;"> Signature of Authorized Representative _____ Type or Print Name </div> <div style="width: 45%;"> Date _____ Title </div> </div>				
(39) Name of Contact Person for Claim Telephone Number _____ (_____) _____ Ext. _____				

VICTIMS' STATEMENTS - MINORS**Certification Claim Form****Instructions****FORM
FAM-27**

- (01) Leave blank.
- (02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the place shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.
- (03) to (08) Leave blank.
- (09) If filing a reimbursement claim, enter an "X" in the box on line (09) Reimbursement.
- (10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.
- (11) If filing an amended claim is filed, enter an "X " in the box on line (11) Amended.
- (12) No entry required..
- (13) Enter the amount of reimbursement claim from form VSM-1, line (14).
- (14) If a reimbursement claim is filed after **June 25, 1999**, the claim must be reduced by a late penalty. Enter the product of multiplying line (13) by the factor 0.10 (10% penalty) or \$1,000, whichever is less.
- (15) No entry required.
- (16) Enter the result of subtracting line (14) from line (13).
- (17) Enter the amount from line (16) on line (17), Due from State.
- (18) to (21) Leave blank.
- (22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (24) for the reimbursement claim [e.g., VSM-1, (03)(a), means the information is located on form VSM-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect cost percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35).
- (38) Read the statement "Certification of Claim." If the statement is true, the claim must be dated, signed by the agency's authorized representative and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.
- (39) Enter the name of the person and telephone number that this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

***Address, if delivered by
U.S. Postal Service:***

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250**

***Address, if delivered by
other delivery service:***

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816**

MANDATED COSTS VICTIMS' STATEMENTS - MINORS CLAIM SUMMARY		FORM VSM-1
(01) Claimant	(02) Type of Claim Reimbursement Claimable Period of Costs: 7/1/97 to 8/16/97	
(03) Claim Statistics		

INITIAL CONTACT WITH VICTIMS TO OBTAIN STATEMENTS AND INFORM THEM OF THE PLACE AND TIME OF MINOR DEFENDANTS DISPOSITION HEARINGS

(03)(a) Number of cases (7/1/97 to 8/16/97) in which a minor is alleged to have committed an act that would have been a felony if committed by an adult and the probation officer obtaining and including the victim's statement concerning the offense in the minor defendant's social study.

Initial Contact by Letters (7/1/97 - 8/16/97)

(03)(b) Number of letters sent to victims.

Total hours spent by clerical workers addressing form letters to victims.

(03)(c) Total hours spent by probation officers filling out letters for typing and proof reading the typed letter. If the county is small and their probation officers must do their own typing because no clerical workers are available, enter the time spent for this activity on this line.

(03)(d) Number of follow-up phone calls needed because the victims failed to acknowledge the letter.

Total hours spent by probation officers on the telephone with victims.

Initial Contacts by Telephone (7/1/97 - 8/16/97)

(03)(e) Number of victims contacted by telephone.

Number of victims who consented to a telephone interview.

Total hours spent by probation officers on telephone interviews.

Total hours spent by probation officers on telephone interviews. If the victim preferred an interview through a home or office visit or a place agreed upon, report contacts under line (04)(b) or line (04)(c). For those who sent in a written statement and the statement needed clarification, report subsequent contacts under line (04)(a), (04)(b), or (04)(c), as appropriate.

OF THE NUMBER OF INITIAL CONTACTS, HOW MANY SUBSEQUENT CONTACTS WERE NEEDED BECAUSE THE VICTIM'S STATEMENT NEEDED CLARIFICATION OR THE VICTIM WANTED TO MAKE A STATEMENT THROUGH AN ORAL INTERVIEW.

(04)(a) Number of victims interviewed by telephone.

Total hours spent by probation officers interviewing victims on the telephone.

(04)(b) Number of victims interviewed through an office visit.

Total hours spent by probation officers interviewing victims regarding their statement.

(04)(c) Number of victims interviewed through a home visit or a place agreed upon.

Total hours spent by probation officers interviewing victims regarding their statement.

Total hours spent by probation officers commuting to victims homes.

MANDATED COSTS VICTIMS' STATEMENTS - MINORS CLAIM SUMMARY		FORM VSM-1
(01) Claimant	(02) Type of Claim Reimbursement Claimable Period of Costs: 7/1/97 to 8/16/97	
(03) Claim Statistics		

RECORDING THE VICTIM'S ORAL STATEMENT ON PAPER

(05) Number of victims making a statement through an oral interview. _____

Total hours spent by clerical workers translating and typing statements. _____

PROBATION OFFICERS REVIEWING OF VICTIMS' STATEMENTS AND INCORPORATING IN THE SOCIAL STUDY.

(06) Number of cases involving victims statements. _____

Total hours spent by probation officers reviewing victims' statements and incorporating in the social study. _____

SUPERVISING PROBATION OFFICER REVIEWING THAT PORTION OF THE SOCIAL STUDY WHICH PERTAINS TO VICTIMS' STATEMENTS.

(07) Number of cases involving victim statements. _____

Total hours spent by supervising probation officers reviewing that portion of the social study which pertains to the victims' statements. _____

SUMMARY OF HOURS SPENT

Total hours spent by clerical workers, line (03)(b) + (05). _____

Total hours spent by probation officers, lines (03)(c) + (03)(d) + (03)(e) + (04)(a) + (04)(b) + (04)(c) + (06). _____

Total hours spent by supervising probation officers, line (07). _____

Direct Costs	OBJECT ACCOUNTS				
(08) Reimbursable Components:	(a)	(b)	(c)	(d)	(e)
	Salaries	Benefits	Supplies	Travel	Total Direct Costs
Obtaining Victims Statements					
Indirect Costs					
(09) Indirect Cost Rate	[From ICRP]				%
(10) Total Indirect Cost	[Line (09) x line (08)(a)] or [line (09) x {line (08)(a) + line (08)(b)}]				
(11) Total Direct and Indirect Costs	[Line (08)(e) + line (10)]				
Cost Reduction					
(12) Less: Offsetting Savings, if applicable					
(13) Less: Other Reimbursements, if applicable					
(14) Total Claimed Amount:	[Line (11) - {Line (12) + line (13)}]				

VICTIMS' STATEMENTS - MINORS CLAIM SUMMARY Instructions	FORM VSM-1
--	-----------------------------

- (01) Enter the name of the claimant.
- (02) Type of Claim. No entry required.
- (03) to (07) Enter the information as specified.
- (08) For each reimbursable component enter the total from form VSM-2, line (05), columns (d) through (g) to form VSM-1, line (08). Enter the sum of columns (a) to (d) in column (e).
- (09) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have its own ICRP for the program.
- (10) Multiply Total Salaries, line (08)(a) by the Indirect Cost Rate, line (09). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (08)(a), and Total Benefits, line (08)(b), by the Indirect Cost Rate, line (09).
- (11) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (08)(e) and Total Indirect Costs, line (10).
- (12) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.
- (13) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, other state funds which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.
- (14) Total Claimed Amount. Subtract the sum of line (12), and line (13), from, line (11). Enter the remainder on this line and carry the amount forward to form FAM-27, line (13).

MANDATED COSTS VICTIMS' STATEMENTS - MINORS COMPONENT/ACTIVITY COST DETAIL						FORM VSM-2	
(01) Claimant			(02) Claimable Period of Costs: 7/1/97 to 8/16/97				
(03) Reimbursable Component: Obtaining Victim's Statements							
(04) Description of Expenses: Complete columns (a) through (g).				Object Accounts			
(a) Employee Names, Job Classifications, Functions Performed and Description of Services and Supplies	(b) Hourly Rate or Unit cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Supplies	(g) Travel	
(05) Total <input style="width: 50px;" type="text"/> Subtotal <input style="width: 50px;" type="text"/> Page: _____ of _____							

VICTIMS' STATEMENTS - MINORS
COMPONENT/ACTIVITY COST DETAIL
Instructions

FORM
VSM-2

- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Reimbursable Components: Obtaining Victim's Statements. This line identifies the costs which may be claimed on form VSM-2.
- (04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity in block (04), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, and travel expenses. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns							Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked				
Benefits	Title Activities Performed	Benefit Rate	Hours Worked		Benefits = Benefit Rate x Salaries			
Services and Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Used		
Travel	Purpose of Trip Name and Title Departure and Return Date	Per Diem Rate Mileage Rate Travel Cost	Days Miles Travel Mode				Rate x Days or Miles Total Travel Cost	

- (05) Total line (04), columns (d), (e), (f), and (g) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component costs, number each page. Enter totals from line (05), columns (d), (e), (f), and (g) to form VSM-1, block (08) columns (a), (b), (c), and (d).

COURT AUDITS AND PRORATION OF FINES

1. Summary of Chapter 980, Statutes of 1984

Section 1462.5 of the Penal Code as added by Chapter 980, Statutes of 1984, requires that each installment or partial payment of a fine, penalty, forfeiture, or fee shall be prorated among the state and local shares according to the Uniform Accounting System established by the State Controller. Amended Government Code Section 71383 requires the County Auditor to conduct biennial audits of the Superior Court.

Penal Code Section 1462.5 provides for equitable distribution of installment payments to all entities due a share of revenue and upon default of the defendant, all entities realize a proportionate share of the lost revenue.

Amended Government Code Section 71383 requires the county auditor, in conducting audits of the Superior, Municipal, and Justice courts, to review the collection and disbursement activities of probation offices, central collection bureaus, and other agencies having a role in this process. A certified copy of these audits must be submitted to the State Controller within six months after the close of the fiscal year for which the audits were conducted.

On January 26, and April 27, 1989, the Commission on State Mandates determined that the requirements of Penal Code Section 1462.5 and Government Code Section 71383 imposed upon counties a new program or higher level of service within the meaning of Section 6, Article XIII B of the California Constitution and Section 17514 of the Government Code.

2. Eligible Claimants

Any county that incurs increased costs as a direct result of this mandate is eligible to claim reimbursement of these costs for the period of 7/1/97 through 8/16/97.

3. Reimbursable Components

Eligible claimants will be reimbursed for costs incurred during the period 7/1/97 through 8/16/97 for the following activities:

- A. Implementing the guidelines set forth in the Uniform Accounting System established by the State Controller for prorating the distribution of installment payments collected in the courts, county probation offices, or central collection bureaus for fees, fines, forfeitures, and assessments that must be equitably distributed among recipient entities. Costs should be classified into two categories: (1) Phase-in costs, and (2) Ongoing costs. Phase-in costs are costs that are incurred as a direct result of implementing the new proration method. Ongoing costs are increased costs that the local entity will continue to incur after fully implementing the proration method required by Penal Code Section 1462.5. Notwithstanding the type of accounting system used, whether automated, manual, or a hybrid, local entities may incur costs in both categories. Pursuant to Chapter 266, Statutes of 1991, costs of court operations related to proration of fines incurred after January 1, 1989, are not reimbursable for counties participating in the Trial Court Funding Program.

- B. Conducting biennial audits of the Superior Courts, probation offices, central collection bureaus, and other agencies involved in the collection and disbursement process.
- C. Submitting certified copies of the audit to the State Controller's Office within six months after the close of the fiscal year for which the audit is conducted.

More specifically, the following activities /costs are reimbursable:

D. Phase-in Costs (This cost component is not claimable 7/1/97 to 8/16/97)

- (1) System development/automated systems--costs to develop or reprogram the computer application programs to include:
 - (a) Development of new programs and rewriting programs.
 - (b) Purchase of software.
 - (c) Purchase of hardware.
 - (d) Debugging the program.

Reimbursement of automated system costs should be limited to their proportional applicability to the proration and distribution of fees, fines, forfeitures, and assessments required by Chapter 980/84.

- (2) System development/manual system--costs of revising the accounting system to facilitate the application of the change in proration method to include:
 - (a) Revisions of the accounting systems, forms, records, ledgers, summary reports, and distribution reports on the collections activity.
 - (b) Revision of the accounting procedures and operating manuals.
 - (c) Salaries and benefits--costs of staff time to implement the new proration method to include:
 - (i) Meetings--costs of attending meetings to develop the plan for implementing the proration method.
 - (ii) Training--costs of training staff in the proration procedures.

E. Ongoing Costs

- (1) Increased data processing support--costs after implementation of the proration method incurred as a direct result of the increased complexity of the computer programs.
- (2) Increased level of service--cost of staff time directly related to performing the proration distribution required by Penal Code section 1462.5 as compared to the method used prior to the enactment of Penal Code section 1462.5.

F. Biennial Audit Costs

- (1) Preliminary review, including costs to conduct an internal control survey, review prior work papers, prior audit reports, and the cost of conducting a pre-conference hearing.
- (2) Preparation of an audit program, to be used to conduct an audit of Superior Court, probation offices, central collection bureaus, and other agencies involved in the court's collection and disbursement process. The audit program shall comply with the State Controller's Office Manual of Accounting and Audit Guidelines for Municipal and Justice Courts.

- (3) Conducting audits, as outlined in the audit program, of the Superior Courts, probation offices, central collection bureaus, and other agencies involved in this process.
- (4) Preparation of a draft audit report on findings and recommendations.
- (5) Cost to conduct a post conference hearing on findings and recommendations.
- (6) Preparation of a final audit report, including the auditee's comments on the findings and recommendations reviewed in the post conference hearing.
- (7) Issuance of the audit report to the State Controller's Office.
- (8) Contracted Services--contract costs and administrative costs to acquire outside auditing services and oversee the completion of the audits in accordance with the activities listed in items (1) through (7) above.

4. Reimbursement Limitations

- A.** Any offsetting savings or reimbursement the claimant received from any source including, but not limited to, service fees collected, federal funds, and other state funds as a direct result of this mandate, shall be identified and deducted so only the net local cost is claimed.
- B.** Penal Code section 1205(d) requires that a defendant pay the county a fee for processing installment payments. Penal Code section 1205(d), in pertinent part, states the following:
 - (1) "This fee shall equal the administrative and clerical costs, as determined by the Board of Supervisors, except that the fee shall not exceed thirty five dollars (\$35)."
 - (2) Penal Code section 1205(d) allows counties to recover the administrative and clerical costs by establishing and assessing this fee. Generally, actual costs to administer this program will exceed the thirty five dollar (\$35) allowable fee.
 - (3) Counties that charge a fee of thirty five dollars (\$35) prior to the enactment of Penal Code section 1465.2 may claim all allowable reimbursable mandated costs for the increased level of service in performing the mandated activity.
 - (4) Counties that charge a fee less than the thirty five dollars (\$35) prior to the enactment of Penal Code section 1462.5 must demonstrate that their administrative and clerical costs exceed the thirty five dollar (\$35) fee established by Penal Code section 1205(d) in order to be able to claim reimbursable mandated costs.
- C.** Costs of court operations related to proration of fines incurred after January 1, 1989, are not reimbursable for counties participating in the Trial Court Funding Program.

5. Claiming Forms and Instructions

The diagram "Illustration of Claim Forms" provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for form CAP-1 and form CAP-2, provided the format of the report and data fields contained within the report are identical to the claim forms included in these instructions. The claim forms provided with these instructions can be duplicated and used by the claimant to file a reimbursement claim.

A. Form CAP-2, Component/Activity Cost Detail

This form is used to segregate the detailed costs by claim component. A separate form CAP-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed and specify the actual time devoted to each function by each employee, productive hourly rate, and related fringe benefits.

Reimbursement for personal services includes compensation paid for salaries, wages, and employee fringe benefits. Employee fringe benefits include regular compensation paid to an employee during periods of authorized absences (e.g., annual leave, sick leave) and the employer's contribution of social security, pension plans, insurance, and worker's compensation insurance. Fringe benefits are eligible for reimbursement when distributed equitably to all job activities which the employee performs.

Source documents may include, but are not limited to, time logs evidencing actual costs claimed under Reimbursable Activities, time sheets, payroll records, canceled payroll warrants, organization charts, duty statements, pay rate schedules, and other documents evidencing the expenditure.

(2) Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of the materials and supplies consumed specifically for the purposes of this mandate. Purchases shall be claimed at the actual price after deducting cash discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged based on a recognized method of costing, consistently applied.

Source documents may include, but are not limited to, general and subsidiary ledgers, invoices, purchase orders, receipts, canceled warrants, inventory records, and other documents evidencing the expenditure.

(3) Contract Services

Provide the name(s) of the contractor(s) who performed the services, including any fixed contracts for services. Describe the reimbursable activity(ies) performed by each named contractor and give the number of actual hours spent on the activities, if applicable. Show the inclusive dates when services were performed and itemize all costs for those services. Attach consultant invoices with the claim.

Source documents may include, but are not limited to, general and subsidiary ledgers, contracts, invoices, canceled warrants, and other documents evidencing the validity of the expenditure.

(4) Travel

Travel expenses for mileage, per diem, lodging, and other employee entitlements are reimbursable in accordance with the rules of the local jurisdiction. Give the name(s) of the traveler(s), purpose of travel, inclusive travel dates, destination

points, and costs.

Source documents to be maintained by the claimant may include, but are not limited to, receipts, employee travel expense claims, and other documents evidencing the validity of the expenditures.

(5) Fixed Assets

List the cost of the fixed assets that have been acquired specifically for the purpose of this mandate. If the fixed asset is utilized in some way not directly related to the mandated program, only the pro-rata portion of the asset which is used for purposes of the mandated program is reimbursable.

Source documents to be maintained by the claimant may include, but are not limited to, invoices, receipts, purchase orders, and other documents evidencing the validity of the purchases.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

B. Form CAP-1, Claim Summary

This form is used to summarize direct costs by component and compute allowable costs for the mandate. The direct costs summarized on this form are derived from form CAP-2 and are carried forward to form FAM-27.

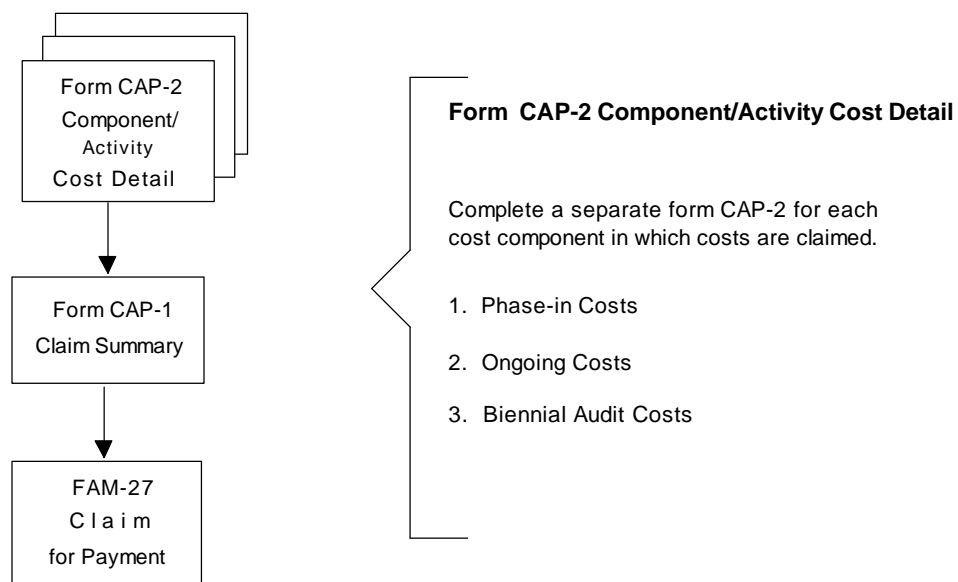
If biennial audit costs are being claimed, the claimant must list all departments involved in the process for the fiscal year. For each department, provide the dates audits were started, the dates audits were concluded, and the dates audit reports were issued for the latest audit conducted in accordance with the State Controller's Office Manual of Accounting and Audit Guidelines for Municipal and Justice Courts.

Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits, as long as the direct labor costs are directly related to the cost of performing the mandate. If an indirect cost rate greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have its own ICRP.

C. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the county. All applicable information from form CAP-1 must be carried forward to this form in order for the State Controller's Office to process the claim for payment.

Illustration of Claim Forms



CLAIM FOR PAYMENT Pursuant to Government Code Section 17561 COURT AUDITS AND PRORATION OF FINES			For State Controller Use Only		
			(19) Program Number 00085		
			(20) Date File _____/_____/_____		
			(21) LRS Input _____/_____/_____		
L A B E L H E R E	(01) Claimant Identification Number		Reimbursement Claim Data		
	(02) Mailing Address		(22) CAP-1, (04)(1)(e)		
	Claimant Name		(23) CAP-1, (04)(2)(e)		
	County of Location		(24) CAP-1, (04)(3)(e)		
	Street Address or P. O. Box		(25) CAP-1, (06)		
	City	State	Zip Code	(26) CAP-1, (08)	
Type of Claim	Estimated Claim	Reimbursement Claim	(27)		
	(03) Estimated <input type="checkbox"/>	(09) Reimbursement <input type="checkbox"/>	(28)		
	(04) Combined <input type="checkbox"/>	(10) Combined <input type="checkbox"/>	(29)		
	(05) Amended <input type="checkbox"/>	(11) Amended <input type="checkbox"/>	(30)		
Fiscal Year of Cost	(06)	(12) 7/1/97 to 8/16/97	(31)		
Total Claimed	(07)	(13)	(32)		
Less: 10% Late Penalty, not to exceed \$1000		(14)	(33)		
Less: Estimated Claim Payment Received		(15)	(34)		
Net Claimed Amount		(16)	(35)		
Due from State	(08)	(17)	(36)		
Due to State		(18)	(37)		
(38) CERTIFICATION OF CLAIM					
<p>In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 980, Statutes of 1984; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.</p> <p>I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 980, Statutes of 1984.</p> <p>The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 980, Statutes of 1984, set forth on the attached statements.</p>					
Signature of Authorized Representative		Date			
_____		_____			
Type or Print Name		Title			
_____		_____			
(39) Name of Contact Person for Claim		Telephone Number			
_____		(_____) _____ Ext. _____			

COURT AUDITS AND PRORATION OF FINES

Certification Claim Form

Instructions

FORM
FAM-27

- (01) Leave blank.
- (02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the place shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.
- (03) through (8) Leave blank.
- (09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.
- (10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.
- (11) If filing an amended claim enter an "X " in the box on line (11) Amended.
- (12) No entry required.
- (13) Enter the amount of reimbursement claim from form CAP-1, line (11). If more than one form CAP-1 is completed due to multiple department involvement in this mandate, add line (11) of each form CAP-1.
- (14) If a reimbursement claim is filed after **June 25, 1999**, the claim must be reduced by a late penalty. Enter the product of multiplying line (13) by the factor 0.10 (10% penalty) or \$1,000, whichever is less.
- (15) No entry required.
- (16) Enter the result of subtracting line (14) from line (13).
- (17) Enter the amount from line (16) on line (17), Due from State.
- (18) through (21) Leave blank
- (22) through (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (26) for the reimbursement claim [e.g., CAP-1, (03)(1), means the information is located on form CAP-1, line (03)(1). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect cost percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35).
- (38) Read the statement "Certification of Claim." If the statement is true, the claim must be dated, signed by the agency's authorized representative and must include the person's name and title, typed or printed Claims cannot be paid unless accompanied by a signed certification.
- (39) Enter the name of the person and telephone number that this office should contact if additional information is required.

Address, if delivered by:
U.S. Postal Service

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by:
Other delivery service

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 9581 6

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

MANDATED COSTS COURT AUDITS AND PRORATION OF FINES CLAIM SUMMARY					FORM CAP-1
(01) Claimant		(02) Type of Claim Reimbursement Claimable Period for Costs: 7/1/97 to 8/16/97			
Claim Statistics					
(03) Biennial Audit Activity		Dates of Audit Activity			
Departments Audited		Started	Concluded	Report	
1.					
2.					
3.					
4.					
5.					
6.					
Direct Costs		Object Accounts			
(04) Reimbursable Components	(a) Salaries	(b) Benefits	(c) Services and Supplies	(d) Fixed Assets	(e) Total
1. Phase-in Costs (Not Claimable)					
2. Ongoing Costs					
3. Biennial Audit Costs					
(05) Total Direct Costs					
Indirect Costs					
(06) Indirect Cost Rate [From ICRP]					%
(07) Total Indirect Costs [Line (06) x line (05)(a)] or [line (06) x {line (05)(a) + line (05)(b)}]					
(08) Total Direct and Indirect Costs: [Line (05)(e) + line (07)]					
Cost Reduction					
(09) Less: Offsetting Savings, if applicable					
(10) Less: Other Reimbursements, if applicable					
(11) Total Claimed Amount [Line (08) - {Line (09) + Line (10)}]					

COURT AUDITS AND PRORATION OF FINES
CLAIM SUMMARY
Instructions

FORM
CAP-1

- (01) Enter the name of the claimant.
- (02) Type of Claim. No entry required.
- (03) Biennial Audit Activity. List all departments or agencies involved in the process or which audit costs are being claimed. For each, provide the dates audits were started, the dates, audits were concluded and the dates audit reports were issued or the latest audit conducted in accordance with the State Controller's Office Manual of Accounting and Audit Guidelines for Municipal and Justice Courts. If additional spaces are needed, attach a supplemental schedule.
- (04) Reimbursable Components. For each reimbursable component enter the total from form CAP-2, line (05) columns (d), (e), (f), and (g) to form CAP-1, block (04) columns (a) to (d) in the appropriate row. Total each row.
- (05) Total Direct Costs. Total columns (a) through (e).
- (06) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have their own ICRP for the program.
- (07) Total Indirect Costs. Multiply Total Salaries, line (05)(a), by the Indirect Cost Rate, line (06). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (05)(a), and Total Benefits, line (05)(b), by the Indirect Cost Rate, line (06).
- (08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(e), and Total Indirect Costs, line (07).
- (09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.
- (10) Less: Other Reimbursements, if applicable. Enter the amount of Penal Code Section 1205(d) fee received. Counties that charged a \$35 fee prior to the enactment of Penal Code Section 1465.2 must offset the amount collected if administrative and clerical costs are claimed. For counties who charged a fee less than \$35 prior to the enactment of Section 1205(d), they must demonstrate that their administrative and clerical costs exceed \$35 if costs are to be claimed. Also list any other reimbursements received from any local agency source, (i.e., federal, other state programs, foundations, etc..) Submit a schedule detailing the reimbursement sources and amounts.
- (11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements line (10), from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (13) for the Reimbursement Claim.

MANDATED COSTS COURT AUDITS AND PRORATION OF FINES COMPONENT/ACTIVITY COST DETAIL						FORM CAP-2	
(01) Claimant			(02) Claimable Period of Costs: 7/1/97 to 8/16/97				
(03) Reimbursable Component: Check only one box per form to identify the component being claimed.							
<input type="checkbox"/> Phase-in Costs		<input type="checkbox"/> On-going Costs					
<input type="checkbox"/> Biennial Audit Costs							
(04) Description of Expenses: Complete columns (a) through (g).				Object Accounts			
(a)	(b)	(c)	(d)	(e)	(f)	(g)	
Employee Names, Job Classifications, Functions Performed and Description of Services and Supplies	Hourly Rate or Unit cost	Hours Worked or Quantity	Salaries	Benefits	Services and Supplies	Fixed Assets	
(05) Total <input type="text"/> Subtotal <input type="text"/> Page: ____ of ____							

COURT AUDITS AND PRORATION OF FINES
COMPONENT/ACTIVITY COST DETAIL
Instructions

FORM
CAP-2

- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form CAP-2 shall be prepared for each component which applies.
- (04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To ~~add~~ costs for the component activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, and contract services. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns							Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked				
Benefits	Title							
	Activities	Benefit Rate	Hours Worked		Benefits = Benefit Rate x Salaries			
Services and Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Used		
Contract Services	Name of Contractor	Hourly Rate	Hours Worked			Itemized Cost of Services Performed		
	Specific Tasks Performed		Inclusive Dates of Service					Invoice
Travel	Purpose of Trip Name and Title Departure and Return Date	Per Diem Rate Mileage Rate	Days Miles Trans. Cost			(b) x (c) Rate x Days or Miles Total Trans. Cost		
Fixed Assets	Description of Equipment Purchased, Asset	Unit Cost	Quantity Used				Total Fixed Assets Purchased	Invoice

- (05) Total line (04), columns (d), (e), (f), and (g) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component costs, number each page. Enter totals from line (05), columns (d), (e), (f), and (g) to form CAP-1, block (04) columns (a), (b), (c), and (d) in the appropriate row.

DOMESTIC VIOLENCE INFORMATION

1. Summary of Chapters 1609/84 and 668/85

Title 5 commencing with Section 13700 of the Penal Code as added by Chapter 1609, Statutes of 1984, and amended by Chapter 668, Statutes of 1985, requires all law enforcement agencies in the State of California to:

- A. Develop, adopt, and implement written policies and standards for law enforcement officers' response to domestic violence calls by January 1, 1986. Existing and new local policies must be in writing and available to the public upon request and must include specific standards for a range of related activities.
- B. Develop an incident report form and maintain records of all protection orders with respect to domestic violence incidents. This information must be made readily available to law enforcement officers responding to domestic violence related calls for assistance. Provide such information, on a monthly basis, to the Attorney General's Office.
- C. Provide specific written information to the victims of domestic violence pursuant to Section 13701 of the Penal Code.

2. Eligible Claimants

Any city, county, city and county, or special district employing peace officers and incurring increased costs as a direct result of this mandate is eligible to claim reimbursement of these costs.

3. Reimbursable Components

Eligible claimants will be reimbursed for costs incurred during the period 7/1/97 through 8/16/97 for the following activities:

A. Development of an Information System

(1) Development of a System to Record Incoming Domestic Violence Calls

Costs associated with the development of a system for recording all domestic violence related calls for assistance to include whether weapons are involved.

(2) Development of a Domestic Violence Incident Report Form

Costs associated with the development of a Domestic Violence Incident Report form to record and report domestic violence related calls.

(3) Development of a Statement of Information

Costs incurred after January 1, 1986, for the preparation of a Statement of Information for victims of incidents of domestic violence.

(4) Development and Maintenance of a Protective Order System

Costs for the establishment of a system to verify temporary restraining orders, stay away orders, and proof of service at the scene of any incidents of domestic violence. Also reimbursable are costs for the maintenance of all protection order

records of an individual accused of illegal behavior, and who applied for, and was granted, such an order to restrain from the home or other court defined areas.

B. Responding to Domestic Violence Incidents

(1) Utilization of the System to Verify Court Orders

Costs for the utilization of a system to verify temporary restraining orders, stay away orders, and proof of service at the scene of any incident of domestic violence.

(2) Costs are reimbursable for activities related to furnishing victims at the scene of a domestic violence incident with written information regarding legal options and available assistance and any necessary explanation of that information, or for providing such information via telephone when law enforcement response is not required.

Costs for time spent by police officers including, but not limited to, responding to domestic violence calls, restoring order, investigation, etc., are **not reimbursable**, except for time spent related to activities in items 3B(1), 3B(2), and 3B(3).

(3) Completing Domestic Violence Incident Reports

Costs of writing mandated reports that include domestic violence reports, incident , or crime reports directly related to the domestic violence incident.

C. Reports to the Attorney General's Office

Monthly Summary Reports to the State Attorney General

Costs of monthly summary reports that show the total number of domestic violence calls received, and the number of such cases involving weapons, compiled by the local agency and submitted to the Attorney General's Office.

4. Reimbursement Limitation

Any offsetting savings or reimbursement the claimant received from any source including, but not limited to, service fees collected, federal funds, or other state funds as a direct result of this mandate, must be deducted from the amount claimed.

5. Claiming Forms and Instructions

The diagram entitled "Illustration of Claim Forms" provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for form DVI-1 and form DVI-2, provided the format of the report and data fields contained within the report are identical to the claim forms included in this chapter. The claim forms provided in this chapter can be duplicated and used by the claimant to file a reimbursement claim.

A. Form DVI-2, Component/Activity Cost Detail

This form is used to segregate the detailed costs by claim component. A separate DVI-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed and specify the actual time devoted to each function by each employee, productive hourly rate, and related fringe benefits.

Reimbursement for personal services includes compensation paid for salaries, wages, and employee fringe benefits. Employee fringe benefits include regular compensation paid to an employee during periods of authorized absences (e.g., annual leave, sick leave) and the employer's contribution of social security, pension plans, insurance, and worker's compensation insurance. Fringe benefits are eligible for reimbursement when distributed equitably to all job activities which the employee performs.

Source documents may include, but are not limited to, time logs evidencing actual costs claimed under Reimbursable Activities, time sheets, payroll records, canceled payroll warrants, organization charts, duty statements, pay rate schedules, and other documents evidencing the expenditure.

(2) Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of the materials and supplies consumed specifically for the purposes of this mandate. Purchases shall be claimed at the actual price after deducting cash discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged based on a recognized method of costing, consistently applied.

Source documents may include, but are not limited to, general and subsidiary ledgers, invoices, purchase orders, receipts, canceled warrants, inventory records, and other documents evidencing the expenditure.

(3) Contract Services

Provide the name(s) of the contractor(s) who performed the services, including any fixed contracts for services. Describe the reimbursable activity(ies) performed by each named contractor and give the number of actual hours spent on the activities, if applicable. Show the inclusive dates when services were performed and itemize all costs for those services. Attach consultant invoices with the claim.

Source documents may include, but are not limited to, general and subsidiary ledgers, contracts, invoices, canceled warrants, and other documents evidencing the validity of the expenditure.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

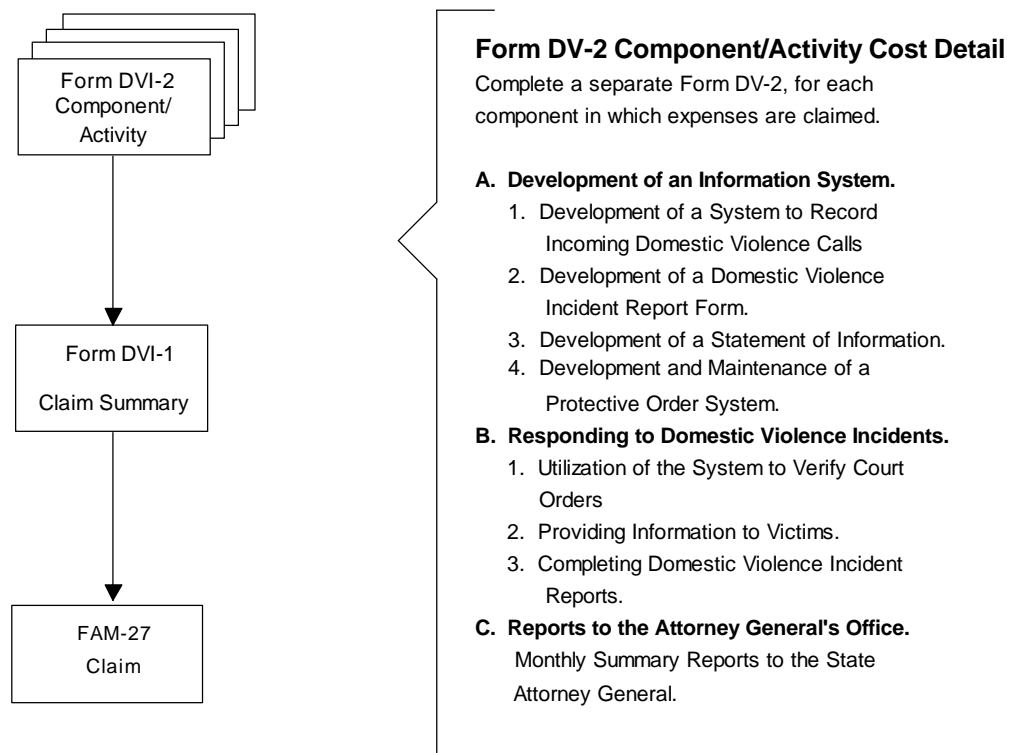
B. Form DVI-1, Claim Summary

This form is used to summarize direct costs by component and compute allowable indirect costs for the mandate. The direct costs summarized on this form are derived from form DVI-2 and are carried forward to FAM-27.

Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits, as long as the direct labor costs are directly related to the cost of performing the mandate. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have its own ICRP for the program.

C. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the local agency. All applicable information from form DVI-1 must be carried forward to this form in order for the State Controller's Office to process the claim for payment.

ILLUSTRATION OF CLAIM FORMS

CLAIM FOR PAYMENT Pursuant to Government Code Section 17561 DOMESTIC VIOLENCE INFORMATION			For State Controller Use Only	
			(19) Program Number 00015	
			(20) Date File _____/_____/_____	
			(21) LRS Input _____/_____/_____	
L A B E L H E R E	(01) Claimant Identification Number		Reimbursement Claim Data	
	(02) Mailing Address		(22) DVI-1, (03)	
	Claimant Name		(23) DVI-1, (04)(1)(d)	
	County of Location		(24) DVI-1, (04)(2)(d)	
	Street Address or P. O. Box		(25) DVI-1, (04)(3)(d)	
	City State Zip Code		(26) DVI-1, (06)	
			(27)	
Type of Claim	Estimated Claim	Reimbursement Claim	(28)	
(03) Estimated <input type="checkbox"/>	(09) Reimbursement <input type="checkbox"/>	(29)		
(04) Combined <input type="checkbox"/>	(10) Combined <input type="checkbox"/>	(30)		
(05) Amended <input type="checkbox"/>	(11) Amended <input type="checkbox"/>			
Fiscal Year of Cost	(06)	(12) 7/1/97 to 8/16/97	(31)	
Total Claimed	(07)	(13)	(32)	
Less: 10% Late Penalty, not to exceed \$1000		(14)	(33)	
Less: Estimated Claim Payment		(15)	(34)	
Net Claimed Amount		(16)	(35)	
Due from State	(08)	(17)	(36)	
Due to State		(18)	(37)	
(38) CERTIFICATION OF CLAIM <p>In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1609, Statutes of 1984 and Chapter 668, Statutes of 1985; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.</p> <p>I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1609, Statutes of 1984 and Chapter 668, Statutes of 1985.</p> <p>The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1609, Statutes of 1984 and Chapter 668, Statutes of 1985, set forth on the attached statements.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div>Signature of Authorized Representative</div> <div>Date</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div>_____</div> <div>_____</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div>Type or Print Name</div> <div>Title</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div>_____</div> <div>_____</div> </div>				
(39) Name of Contact Person for Claim		Telephone Number		
_____		(____) _____ Ext. _____		

DOMESTIC VIOLENCE INFORMATION**Certification Claim Form****Instructions****FORM
FAM-27**

- (01) Leave blank.
- (02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the place shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.
- (03) to (08) Leave blank.
- (09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.
- (10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.
- (11) If filing an amended claim, enter an "X " in the box on line (11) Amended.
- (12) No entry required.
- (13) Enter the amount of reimbursement claim from form DVI-1, line (11). If more than one form DVI-1 is completed due to multiple department involvement in this mandate, add line (11) of each form DVI-1.
- (14) If a reimbursement claim is filed after **June 25, 1999**, the claim must be reduced by a late penalty. Enter the product of multiplying line (13) by the factor 0.10 (10% penalty) or \$1,000, whichever is less.
- (15) No entry required.
- (16) Enter the result of subtracting line (14) from line (13).
- (17) Enter the amount from line (16) on line (17), Due from State.
- (18) to (21) Leave blank.
- (22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (26) for the reimbursement claim [e.g., DVI-1, (03), means the information is located on form DVI-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect cost percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35).
- (38) Read the statement "Certification of Claim." If the statement is true, the claim must be dated, signed by the agency's authorized representative and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.
- (39) Enter the name of the person and telephone number that this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

*Address, if delivered by:
U.S. Postal Service*

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250**

*Address, if delivered by:
Other delivery service*

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816**

MANDATED COSTS DOMESTIC VIOLENCE INFORMATION CLAIM SUMMARY				FORM DVI-1
(01) Claimant		(02) Type of Claim Reimbursement Claimable Period of Costs: 7/1/97 to 8/16/97		
Claim Statistics				
(03) Number of domestic violence incidents reported for the period 7/1/97 to 8/16/97				
Direct Costs		Object Accounts		
(04) Reimbursable Components		(a) Salaries	(b) Benefits	(c) Services and Supplies
1. Development of an Information System				(d) Total
2. Responding to Domestic Violence Incidents				
3. Reports to the Attorney General's Office				
(05) Total Direct Costs				
Indirect Costs				
(06) Indirect Cost Rate [From ICRP]				%
(07) Total Indirect Costs [Line (06) x line (05)(a)] or [line (06) x {line (05)(a) + line (05)(b)}]				
(08) Total Direct and Indirect Costs: [Line (05)(d) + line (07)]				
Cost Reduction				
(09) Less: Offsetting Savings, if applicable				
(10) Less: Other Reimbursements, if applicable				
(11) Total Claimed Amount [Line (08) - {Line (09) + Line (10)}]				

DOMESTIC VIOLENCE INFORMATION CLAIM SUMMARY Instructions	FORM DVI-1
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- (01) Enter the name of the claimant.
- (02) Type of Claim. No entry required.
- (03) Enter the number of domestic violence incidents that were reported for the period 7/1/97 to 8/16/97.
- (04) Reimbursable Components. For each reimbursable component enter the total from form DVI-2, line (05), columns (d), (e), and (f).
- (05) Total Direct Costs. Total columns (a) through (d).
- (06) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have their own ICRP for the program.
- (07) Total Indirect Costs. Multiply Total Salaries, line (05)(a), by the Indirect Cost Rate, line (06). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (05)(a), and Total Benefits, line (05)(b), by the Indirect Cost Rate, line (06).
- (08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(d), and Total Indirect Costs, line (07).
- (09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.
- (10) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including but not limited to, service fees collected, federal funds, and other state funds which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.
- (11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10), from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (13) for the Reimbursement Claim.

MANDATED COSTS DOMESTIC VIOLENCE INFORMATION COMPONENT/ACTIVITY COST DETAIL					FORM DVI-2
(01) Claimant			(02) Fiscal Year Costs Were Incurred		
(03) Reimbursable Component: Check only one box per form to identify the component being claimed.					
<input type="checkbox"/> Development of an Information System					
<input type="checkbox"/> Responding to Domestic Violence Incidents <input type="checkbox"/> Reports to the Attorney General's Office					
(04) Description of Expenses: Complete columns (a) through (f).				Object Accounts	
(a)	(b)	(c)	(d)	(e)	(f)
Employee Names, Job Classifications, Functions Performed and Description of Services and Supplies	Hourly Rate or Unit cost	Hours Worked or Quantity	Salaries	Benefits	Services and Supplies
(05) Total <input type="text"/>			Subtotal <input type="text"/>		
Page: _____ of _____					

DOMESTIC VIOLENCE INFORMATION COMPONENT/ACTIVITY COST DETAIL Instructions	FORM DVI-2
--	-----------------------------

- (01) Enter the name of the claimant.
- (02) Enter the fiscal year for which costs were incurred.
- (03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form DVI-2 shall be prepared for each component which applies.
- (04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in block (03), enter the employee names, position titles, a brief description of their activities performed, actual e spent by each employee, productive hourly rates, fringe benefits, supplies used, and contract services. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits	Title						
	Activities Performed	Benefit Rate	Hours Worked		Benefits = Benefit Rate x Salaries		
Services and Supplies							
Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Used	
Contract Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service			Itemized Cost of Services Performed	Invoice

- (05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component costs, number each page. Enter totals from line (05), columns (d), (e), and (f) to form DVI-1, block (04) columns (a), (b), and (c) in the appropriate row.

PROPERTY TAXATION: FAMILY TRANSFERS

1. Summary of Chapter 48/87

Chapter 48, Statutes of 1987, as added by Section 63.1 of the Revenue and Taxation Code, redefines change of ownership to exclude specific real property transactions, requires that certain certifications be provided to the assessor before the exclusions could be allowed, and directs the assessor to make quarterly reports to the State Board of Equalization on specific purchases or transfers made on or after November 6, 1986.

On September 14, 1988, the Commission on State Mandates determined that the requirements of Proposition 58, as added by Chapter 48, Statutes of 1987, and amended by Section 63.1 of the Revenue and Taxation Code, resulted in state mandated costs that are reimbursable pursuant to Part 7 (commencing with Government Code Section 17500) of Division 4 of Title 2.

2. Eligible Claimants

Any county incurring increased costs as a direct result of this mandate is eligible to claim reimbursement of these costs.

3. Reimbursable Components

Eligible claimants will be reimbursed for costs incurred for the period 7/1/97 through 8/16/97 for the following activities:

Cost of Preparing Reports

The cost of preparing reports that have been filed with the State Board of Equalization as required by the quarterly reporting requirements of Subdivision (d) of Section 63.1 of the Revenue and Taxation Code. Allowable costs include salaries and benefits, supplies, postage, computer programming and maintenance, overhead, and related costs that are incurred in providing the reports required by the State.

4. Reimbursement Limitations

- A. Any offsetting savings or reimbursement the claimant received from any source, including but not limited to, service fees collected, federal funds, and other state funds as a direct result of this mandate, shall be identified and deducted so only the net local cost is claimed.
- B. The county's cost to process and verify claims for exclusion of inter-family transfers from reassessment are not eligible for reimbursement.
- C. Costs incurred as a result of prior activities related to the implementation of Proposition 58 must be **offset** against the cost of preparing and submitting quarterly reports to the State Board of Equalization as required by Chapter 48, Statutes of 1987 [i.e., the cost of activities that are no longer performed by the county but were done prior to the passage of Chapter 48/87 to ensure that the property being transferred does not exceed \$1,000,000 in value, must be deducted from the cost of the claims].

5. Claiming Forms and Instructions

The diagram entitled, "Illustration of Claim Forms", provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for form PTFT-1 and form PTFT-2, provided the format of the report and data fields contained within the report are identical to the claim forms included in this chapter. The claim forms provided in this chapter can be duplicated and used by the claimant to file a reimbursement claim.

A. Form PTFT-2, Component/Activity Cost Detail

This form is used to segregate the detailed costs by claim component. A separate form PTFT-2 must be completed for each component being claimed. Cost reported on this form must be supported as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed and specify the actual time devoted to each function by each employee, productive hourly rate, and related fringe benefits.

Reimbursement for personal services includes compensation paid for salaries, wages, and employee fringe benefits. Employee fringe benefits include regular compensation paid to an employee during periods of authorized absences (e.g., annual leave, sick leave) and the employer's contribution of social security, pension plans, insurance, and worker's compensation insurance. Fringe benefits are eligible for reimbursement when distributed equitably to all job activities which the employee performs.

Source documents may include, but are not limited to, time logs evidencing actual costs claimed under Reimbursable Activities, time sheets, payroll records, canceled payroll warrants, organization charts, duty statements, pay rate schedules, and other documents evidencing the expenditure.

(2) Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of the materials and supplies consumed specifically for the purposes of this mandate. Purchases shall be claimed at the actual price after deducting cash discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged based on a recognized method of costing, consistently applied.

Source documents may include, but are not limited to, general and subsidiary ledgers, invoices, purchase orders, receipts, canceled warrants, inventory records, and other documents evidencing the expenditure.

(3) Contract Services

Provide the name(s) of the contractor(s) who performed the services, including any fixed contracts for services. Describe the reimbursable activity(ies) performed by each named contractor and give the number of actual hours spent on the activities, if applicable. Show the inclusive dates when services were performed and itemize all costs for those services. Attach consultant invoices with the claim.

Source documents may include, but are not limited to, general and subsidiary ledgers, contracts, invoices, canceled warrants, and other documents evidencing the validity of the expenditure.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

B. Form PTFT-1, Claim Summary

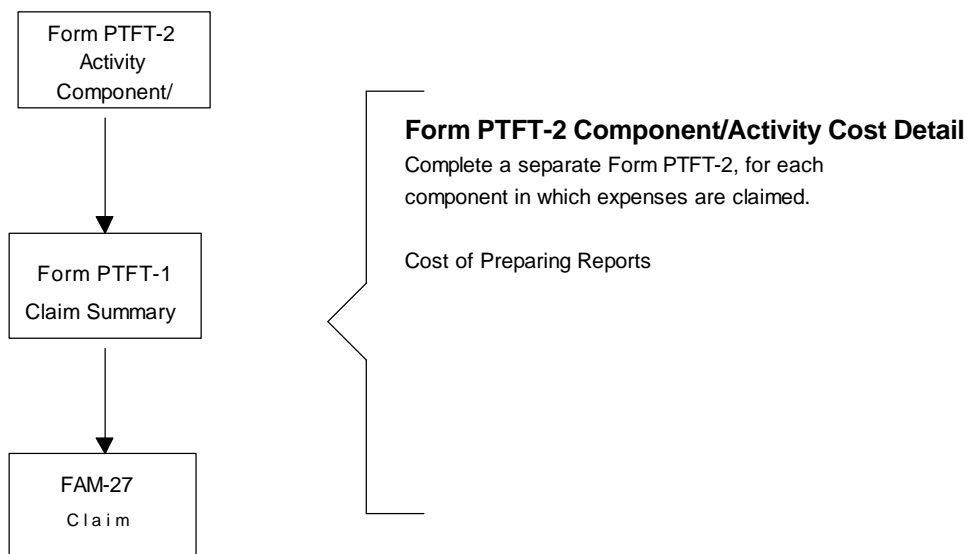
This form is used to summarize direct costs by component and compute allowable indirect costs for the mandate. The direct costs summarized on this form are derived from forms PTFT-2 and are carried forward to form FAM-27.

Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits, as long as the direct labor costs are directly related to the cost of performing the mandate. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have its own ICRP for the program

C. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the county. All applicable information from form PTFT-1 must be carried forward to this form in order for the State Controller's Office to process the claim for payment.

ILLUSTRATION OF CLAIM FORMS



CLAIM FOR PAYMENT Pursuant to Government Code Section 17561 PROPERTY TAXATION: FAMILY TRANSFERS			For State Controller Use Only	
<div style="display: flex; align-items: center;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; margin-right: 5px;">LABEL HERE</div> <div style="flex-grow: 1;"> (01) Claimant Identification Number (02) Mailing Address Claimant Name County of Location Street Address or P. O. Box City State Zip Code </div> </div>			(19) Program Number 00052 (20) Date File ____/____/____ (21) LRS Input ____/____/____	
			Reimbursement Claim Data	
			(22) PTFT-1, (03) (23) PTFT-1, (04)(d) (24) PTFT-1, (05) (25) (26)	
			(27) (28) (29) (30)	
Type of Claim	Estimated Claim (03) Estimated <input type="checkbox"/> (04) Combined <input type="checkbox"/> (05) Amended <input type="checkbox"/>	Reimbursement Claim (09) Reimbursement <input type="checkbox"/> (10) Combined <input type="checkbox"/> (11) Amended <input type="checkbox"/>	(31) (32) (33) (34) (35) (36) (37)	
Fiscal Year of Cost	(06)	(12) 7/1/97 to 8/16/97		
Total Claimed	(07)	(13)		
Less: 10% Late Penalty, not to exceed \$1000		(14)		
Less: Estimated Claim Payment Received		(15)		
Net Claimed Amount		(16)		
Due from State	(08)	(17)		
Due to State		(18)		
(38) CERTIFICATION OF CLAIM <p>In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 48, Statutes of 1987; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.</p> <p>I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 48, Statutes of 1987.</p> <p>The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 48, Statutes of 1987, set forth on the attached statements.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%;"> Signature of Authorized Representative _____ Type or Print Name </div> <div style="width: 45%;"> Date _____ Title </div> </div>				
(39) Name of Contact Person for Claim Telephone Number _____ (____) _____ Ext. _____				

PROPERTY TAXATION: FAMILY TRANSFERS
Certification Claim Form
Instructions

FORM
FAM-27

- (01) Leave blank.
- (02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the place shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.
- (03) to (08) Leave blank.
- (09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.
- (10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.
- (11) If filing an amended claim, enter an "X " in the box on line (11) Amended.
- (12) No entry required.
- (13) Enter the amount of reimbursement claim from form PTFT-1, line (10).
- (14) If a reimbursement claim is filed after **June 25, 1999**, the claim must be reduced by a late penalty. Enter the product of multiplying line (13) by the factor 0.10 (10% penalty) or \$1,000, whichever is less.
- (15) No entry required.
- (16) Enter the result of subtracting line (14) from line (13).
- (17) Enter the amount from line (16) on line (17), Due from State.
- (18) to (21) Leave blank.
- (22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (24) for the reimbursement claim [e.g., PTFT-1, (03), means the information is located on form PTFT-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect cost percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35).
- (38) Read the statement "Certification of Claim." If the statement is true, the claim must be dated, signed by the agency's authorized representative and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.
- (39) Enter the name of the person and telephone number that this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by:
U.S. Postal Service

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by:
Other delivery service

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MANDATED COSTS PROPERTY TAXATION: FAMILY TRANSFERS CLAIM SUMMARY				FORM PTFT-1	
(01) Claimant		(02) Type of Claim Reimbursement Claimable Period of Costs: 7/1/97 to 8/16/97			
Claim Statistics					
(03)					
Direct Costs		Object Accounts			
(04) Reimbursable Components:		(a)	(b)	(c)	(d)
		Salaries	Benefits	Services and Supplies	Total
Cost of Preparing Reports					
Indirect Costs					
(05) Indirect Cost Rate [From ICRP]					
(06) Total Indirect Costs [Line (06) x line (04)(a)] or [line (06) x {line (04)(a) + line (04)(b)}]					
(07) Total Direct and Indirect Costs: [Line (04)(d) + line (06)]					
Cost Reduction					
(08) Less: Offsetting Savings, if applicable					
(09) Less: Other Reimbursements, if applicable					
(10) Total Claimed Amount [Line (07) - {Line (08) + Line (09)}]					

PROPERTY TAXATION: FAMILY TRANSFERS
CLAIM SUMMARY
Instructions

FORM
PTFT-1

- (01) Enter the name of the claimant.
- (02) Type of Claim. No entry required.
- (03) No entry required.
- (04) Reimbursable Components. For each reimbursable component enter the total from form PTFT-2, line (05) columns (d), (e), and (f) to form PTFT-1, block (04), columns (a), (b), and (c). Total the row.
- (05) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have their own ICRP for the program.
- (06) Total Indirect Costs. Multiply Total Salaries, line (04)(a), by the Indirect Cost Rate, line (05). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (04)(a), and Total Benefits, line (04)(b), by the Indirect Cost Rate, line (06).
- (07) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (04)(d), and Total Indirect Costs, line (06).
- (08) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.
- (09) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.
- (10) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (08), and Other Reimbursements, line (09), from Total Direct and Indirect Costs, line (07). Enter the remainder on this line and carry the amount forward to form FAM-27, line (13) for the Reimbursement Claim.

MANDATED COSTS PROPERTY TAXATION: FAMILY TRANSFERS COMPONENT/ACTIVITY COST DETAIL					FORM PTFT-2	
(01) Claimant			(02) Claimable Period of Costs: 7/1/97 to 8/16/97			
(03) Reimbursable Component: Cost of Preparing Quarterly Reports.						
(04) Description of Expenses: Complete columns (a) through (f).				Object Accounts		
(a)	(b)	(c)	(d)	(e)	(f)	
Employee Names, Job Classifications, Functions Performed and Description of Services and Supplies	Hourly Rate or Unit cost	Hours Worked or Quantity	Salaries	Benefits	Services and Supplies	
(05) Total <input style="width: 50px;" type="text"/>			Subtotal <input style="width: 50px;" type="text"/>		Page: _____ of _____	

PROPERTY TAXATION: FAMILY TRANSFERS
COMPONENT/ACTIVITY COST DETAIL
Instructions

FORM
PTFT-2

- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form PTFT-2 shall be prepared for each component which applies.
- (04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component, enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, and contract services. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits	Title Activities Performed	Benefit Rate	Hours Worked		Benefits = Benefit Rate x Salaries		
Services and Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Used	
Contract Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service			Itemized Cost of Services Performed	Invoice

- (05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component costs, number each page. Enter totals from line (05), columns (d), (e), and (f) to form PTFT-1, block (04) columns (a), (b), and (c).

CPR POCKET MASKS

1. Summary of Chapter 1334/87

Chapter 1334, Statutes of 1987, added Section 13518.1 to the Penal Code to require every law enforcement agency employing peace officers to provide each peace officer with a portable manual mask and airway assembly designed to prevent the spread of communicable diseases when applying cardiopulmonary resuscitation.

On February 25, 1988, the Commission on State Mandates determined that the requirements of Penal Code Section 13518.1 as added by Chapter 1334, Statutes of 1987, imposed upon local agencies, a new program or higher level of service, within the meaning of Section 6, Article XIII B of the California Constitution and Section 17514 of the Government Code.

2. Eligible Claimants

Any city, county, city and county, or special district (a special district authorized by statute to maintain a police department) that incurred increased costs as a direct result of this mandate is eligible to claim reimbursement of these costs.

3. Reimbursable Components

Law enforcement agencies will be reimbursed for costs incurred for the period 7/1/97 through 8/16/97 for the following activities:

A. Purchase of Masks and/or Airway Assemblies

Purchase of portable manual masks and airway assemblies that meet the guidelines established by the Emergency Medical Services Authority. The per unit reimbursement cost of a portable manual mask shall be \$11.00 per mask, or the actual cost, whichever is less.

B. Repair or Replacement of Portable Masks and/or Airway Assemblies

Purchase of replacement parts, and time spent repairing defective portable masks and airway assemblies.

4. Reimbursement Limitations

Any offsetting savings or reimbursement the claimant received from any source including, but not limited to, service fees collected, federal funds, and other state funds as a result of this mandate, shall be identified and deducted so only the net local cost is claimed.

5. Claiming Forms and Instructions

The diagram entitled, "Illustration of Claim Forms", provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for form CPR-1 and form CPR-2, provided the format of the report and data fields contained within the report are identical to the claim forms included in this chapter. The claim forms provided in this chapter can be duplicated and used by the claimant to file a reimbursement claim.

A. Form CPR-2, Component/Activity Cost Detail

This form is used to segregate the detailed costs by claim component. A separate form CPR-2 must be completed for each component being claimed. Costs reported on this form must be supported as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed and specify the actual time devoted to each function by each employee, productive hourly rate, and related fringe benefits.

Reimbursement for personal services includes compensation paid for salaries, wages, and employee fringe benefits. Employee fringe benefits include regular compensation paid to an employee during periods of authorized absences (e.g., annual leave, sick leave) and the employer's contribution of social security, pension plans, insurance, and worker's compensation insurance. Fringe benefits are eligible for reimbursement when distributed equitably to all job activities which the employee performs.

Source documents may include, but are not limited to, time logs evidencing actual costs claimed under Reimbursable Activities, time sheets, payroll records, canceled payroll warrants, organization charts, duty statements, pay rate schedules, and other documents evidencing the expenditure.

(2) Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of the materials and supplies consumed specifically for the purposes of this mandate. Purchases shall be claimed at the actual price after deducting cash discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged based on a recognized method of costing, consistently applied.

Source documents may include, but are not limited to, general and subsidiary ledgers, invoices, purchase orders, receipts, canceled warrants, inventory records, and other documents evidencing the expenditure.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

B. Form CPR-1, Claim Summary

This form is used to summarize direct costs by component and compute allowable indirect costs for the mandate. The direct costs summarized on this form are derived from forms CPR-2 and are carried forward to FAM-27.

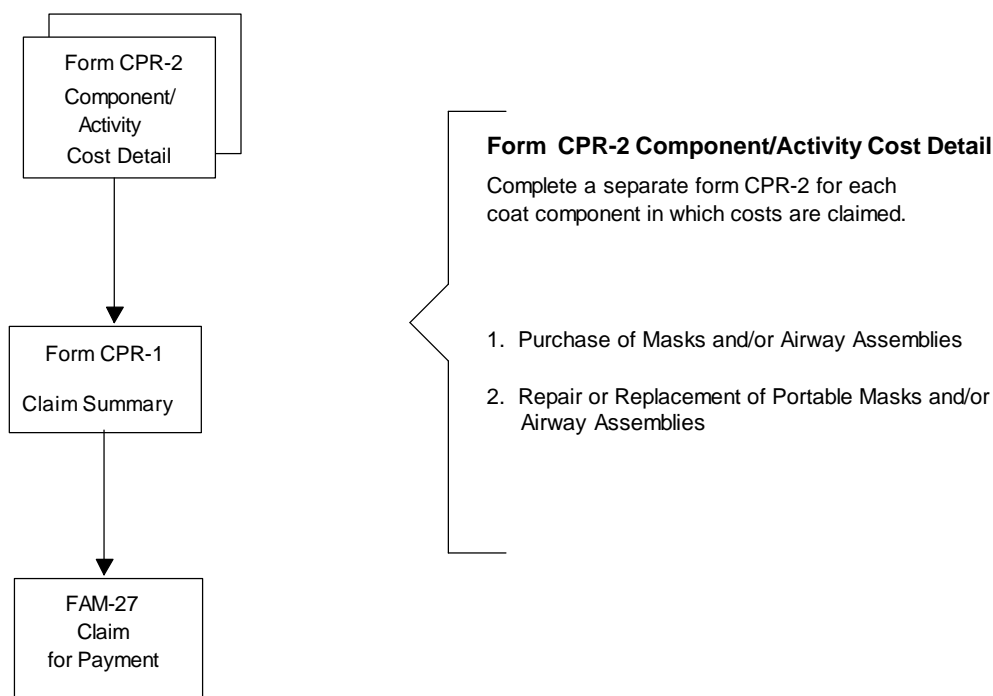
Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits, as long as the direct labor costs are directly related to the cost of performing the mandate. If an indirect cost rate of greater than 10% is used, include the Indirect

Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have its own ICRP for the program.

C. FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the county. All applicable information from form CPR-1 must be carried forward to this form in order for the State Controller's Office to process the claim for payment.

Illustration of Claim Forms



CLAIM FOR PAYMENT Pursuant to Government Code Section 17561 CPR POCKET MASKS			For State Controller Use Only	
(01) Claimant Identification Number			(19) Program Number 00008	
(02) Mailing Address			(20) Date File _____/_____/_____	
Claimant Name			(21) LRS Input _____/_____/_____	
L A B E L H E R E	County of Location		Reimbursement Claim Data	
	Street Address or P. O. Box		(22) CPR-1, (03)(1)	
	City State Zip Code		(23) CPR-1, (03)(2)	
			(24) CPR-1, (03)(3)	
			(25) CPR-1, (04)(1)(d)	
Type of Claim		Estimated Claim	Reimbursement Claim	(26) CPR-1, (04)(2)(d)
		(03) Estimated <input type="checkbox"/>	(09) Reimbursement <input type="checkbox"/>	(27) CPR-1, (06)
		(04) Combined <input type="checkbox"/>	(10) Combined <input type="checkbox"/>	(28)
		(05) Amended <input type="checkbox"/>	(11) Amended <input type="checkbox"/>	(29)
				(30)
Fiscal Year of Cost		(06)	(12) 7/1/97 to 8/16/97	(31)
Total Claimed		(07)	(13)	(32)
Less: 10% Late Penalty, not to exceed \$1000			(14)	(33)
Less: Estimated Claim Payment Received			(15)	(34)
Net Claimed Amount			(16)	(35)
Due from State		(08)	(17)	(36)
Due to State			(18)	(37)
(38) CERTIFICATION OF CLAIM <p>In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1334, Statutes of 1987; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.</p> <p>I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1334, Statutes of 1987.</p> <p>The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1334, Statutes of 1987, set forth on the attached statements.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div>Signature of Authorized Representative</div> <div>Date</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div>_____</div> <div>_____</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div>Type or Print Name</div> <div>Title</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div>_____</div> <div>_____</div> </div>				
(39) Name of Contact Person for Claim		Telephone Number		
_____		(____) _____ Ext. _____		

CPR POCKET MASKS
Certification Claim Form
Instructions

FORM
FAM-27

- (01) Leave blank.
- (02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the place shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.
- (03) to (08) Leave blank.
- (09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.
- (10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.
- (11) If filing an amended claim, enter an "X " in the box on line (11) Amended.
- (12) No entry required.
- (13) Enter the amount of reimbursement claim from form CPR-1, line (11). If more than one form CPR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form CPR-1.
- (14) If a reimbursement claim is filed after **June 25, 1999**, the claim must be reduced by a late penalty. Enter the product of multiplying line (13) by the factor 0.10 (10% penalty) or \$1,000, whichever is less.
- (15) No entry required.
- (16) Enter the result of subtracting line (14) from line (13).
- (17) Enter that amount from line (16) on line (17), Due from State.
- (18) to (21) Leave blank.
- (22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (27) for the reimbursement claim [e.g., CPR-1, (03)(1), means the information is located on form CPR-1, line (03)(1)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect cost percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35).
- (38) Read the statement "Certification of Claim." If the statement is true, the claim must be dated, signed by the agency's authorized representative and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.
- (39) Enter the name of the person and telephone number that this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by:
U.S. Postal Service

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by:
Other delivery service

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MANDATED COSTS CPR POCKET MASKS CLAIM SUMMARY				FORM CPR-1
(01) Claimant		(02) Type of Claim Reimbursement Claimable Period of Costs: 7/1/97 to 8/16/97		
Claim Statistics				
(03) 1. Number of peace officers exclusive of those with primarily clerical or administrative				
2. Number of masks purchased in the 7/1/97 to 8/16/97 period				
3. Number of masks and airway assemblies repaired in the 7/1/97 to 8/16/97 period				
Direct Costs		Object Accounts		
(04) Reimbursable Components:		(a) Salaries	(b) Benefits	(c) Services and Supplies
1. Purchase of masks and/or airway assemblies				(d) Total
2. Repair of masks and/or airway assemblies				
(05) Total Direct Costs				
Indirect Costs				
(06) Indirect Cost Rate [From ICRP]				%
(07) Total Indirect Costs [Line (06) x line (05)(a)] or [line (06) x {line (05)(a) + line (05)(b)}]				
(08) Total Direct and Indirect Costs [Line (05)(d) + line (07)]				
Cost Reduction				
(09) Less: Offsetting Savings, if applicable				
(10) Less: Other Reimbursements, if applicable				
(11) Total Claimed Amount [Line (08) - {Line (09) + Line (10)}]				

CPR POCKET MASKS CLAIM SUMMARY Instructions	FORM CPR-1
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- (01) Enter the name of the claimant.
- (02) Type of Claim. No entry required.
- (03) 1. Enter the number of peace officers exclusive of those with primarily clerical or administrative duties.
 2. Enter the total number of masks purchased in the period 7/1/97 to 8/16/97.
 3. Enter the total number of masks and airway assemblies repaired in the period 7/1/97 to 8/16/97.
- (04) Reimbursable Components. For each reimbursable component enter the total from form CPR-2, line (05) columns (d), (e), and (f).
- (05) Total Direct Costs. Total columns (a) through (d).
- (06) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have its own ICRP for the program.
- (07) Total Indirect Costs. Multiply Total Salaries, line (05)(a), by the Indirect Cost Rate, line (06). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (05)(a), and Total Benefits, line (05)(b), by the Indirect Cost Rate, line (06).
- (08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(d), and Total Indirect Costs, line (07).
- (09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.
- (10) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including but not limited to, service fees collected, federal funds, and other state funds which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.
- (11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10), from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (13) for the Reimbursement Claim.

MANDATED COSTS CPR POCKET MASKS COMPONENT/ACTIVITY COST DETAIL					FORM CPR-2
(01) Claimant			(02) Claimable Period of Costs: 7/1/97 to 8/16/97		
(03) Reimbursable Component: Check only one box per form to identify the component being claimed.					
<input type="checkbox"/> Purchase of Masks and/or Airway Assemblies					
<input type="checkbox"/> Repair or Replacement of Portable Masks and/or Airway Assemblies Repaired					
(04) Description of Expenses: Complete columns (a) through (f).				Object Accounts	
(a)	(b)	(c)	(d)	(e)	(f)
Employee Names, Job Classifications, Functions Performed and/or Number and Description of Masks and/or Airway Assemblies	Hourly Rate or Unit Cost	Hours Worked or Sales Tax	Salaries	Benefits	Services and Supplies
(05) Total <input style="width: 50px;" type="text"/>			Subtotal <input style="width: 50px;" type="text"/> Page: _____ of _____		

CPR POCKET MASKS COMPONENT/ACTIVITY COST DETAIL Instructions	FORM CPR-2
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- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form CPR-2 shall be prepared for each component which applies.
- (04) The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, and supplies used. For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

If "Purchase of Masks/Airway Assemblies" is checked, enter in column (a) the number and description of masks purchased. Masks must meet the established guidelines of the Emergency Medical Service Authority to be reimbursable. In column (b) enter \$11.00 or actual cost, whichever is less and attach the purchase invoice. In column (c) enter the amount of sales tax. In column (f) enter the total cost of masks and/or airway assemblies including sales tax (i.e., $[(a) \times (b)] + (c) = (f)$). In addition, shipping and handling charges may be separately identified in column (c).

If "Repair or Replacement of Portable Masks and/or Airway Assemblies" is checked enter in column (a) the names of the employees, position titles, and a brief description of activity performed. In column (b) enter the employees' productive hourly rate. In column (c) enter the time (hours) spent by employees. In columns (d) and (e) enter the total salaries and benefits for time spent on this mandate as applicable. In addition, include the cost of parts purchased to repair the masks and identify these in column (a), (b), (c), and (f) as appropriate.

Object/ Subobject Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits	Title Activities Performed	Benefit Rate	Hours Worked		Benefits = Benefit Rate x Salaries		
Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Used	

- (05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component costs, number each page. Enter totals from line (05), columns (d), (e), and (f) to form CPR-1, block (04), columns (a), (b), and (c) in the appropriate row.

PERSONAL SAFETY ALARM DEVICES

1. Summary of Title 8, California Code of Regulations, Section 3401 (c)

Title 8, Section 3401(c) of the California Code of Regulations (CCR), as amended in January 1982 by the Occupational Safety and Health Board, requires that after September 30, 1983, local agency fire departments provide a personal alarm device, to be used in conjunction with a self-contained breathing apparatus, for every firefighter engaged in interior structural fire fighting activities.

On March 28, 1984, the Board of Control, predecessor to the Commission on State Mandates, determined that these regulations resulted in state mandated costs that are reimbursable pursuant to Part 7 (commencing with Government Code Section 17500) of Division 4 of Title 2.

2. Eligible Claimants

Any local agency that incurred increased costs as a direct result of this mandate is eligible to claim reimbursement of these costs.

3. Reimbursable Components

Eligible claimants will be reimbursed for costs incurred during the period 7/1/97 to 8/16/97 for the following activities:

A. Initial One-time Costs

(1) Acquisition Cost

The initial costs associated with the acquisition or replacement of personal alarm devices as required by Section 3401(c). Submit invoices with indication of payment as evidence of purchase cost.

(2) Acquisition Time

The cost of staff time spent in procuring or replacing personal alarm devices

(3) Orientation

The cost of staff time spent for initial orientation in the proper use of personal alarm devices for employees unfamiliar with such devices.

B. On-going Costs

(1) Periodic Testing

The cost of staff time spent in periodic testing of personal alarm devices to ensure operability.

(2) Repair Cost

The cost of repairs of personal alarm devices and their component parts (such as batteries).

4. Reimbursement Limitations

Any offsetting savings or reimbursement the claimant received from any source including, but not limited to, service fees collected, federal funds, and other state funds as a direct result of this mandate, shall be identified and deducted so only the net local cost is claimed.

5. Claiming Forms and Instructions

The diagram entitled, "Illustration of Claim Forms," provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for form PSA-1 and form PSA-2, provided the format of the report and data fields contained within the report are identical to the claim forms included in this chapter. The claim forms provided in this chapter can be duplicated and used by the claimant to file a reimbursement claim.

A. Form PSA-2, Component/Activity Cost Detail

This form is used to segregate the detailed costs by claim component. A separate form PSA-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed and specify the actual time devoted to each function by each employee, productive hourly rate, and related fringe benefits.

Reimbursement for personal services includes compensation paid for salaries, wages, and employee fringe benefits. Employee fringe benefits include regular compensation paid to an employee during periods of authorized absences (e.g., annual leave, sick leave) and the employer's contribution of social security, pension plans, insurance, and worker's compensation insurance. Fringe benefits are eligible for reimbursement when distributed equitably to all job activities which the employee performs.

Source documents may include, but are not limited to, time logs evidencing actual costs claimed under Reimbursable Activities, time sheets, payroll records, canceled payroll warrants, organization charts, duty statements, pay rate schedules, and other documents evidencing the expenditure.

(2) Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of the materials and supplies consumed specifically for the purposes of this mandate. Purchases shall be claimed at the actual price after deducting cash discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged based on a recognized method of costing, consistently applied.

Source documents may include, but are not limited to, general and subsidiary ledgers, invoices, purchase orders, receipts, canceled warrants, inventory records, and other documents evidencing the expenditure.

For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

B. Form PSA-1, Claim Summary

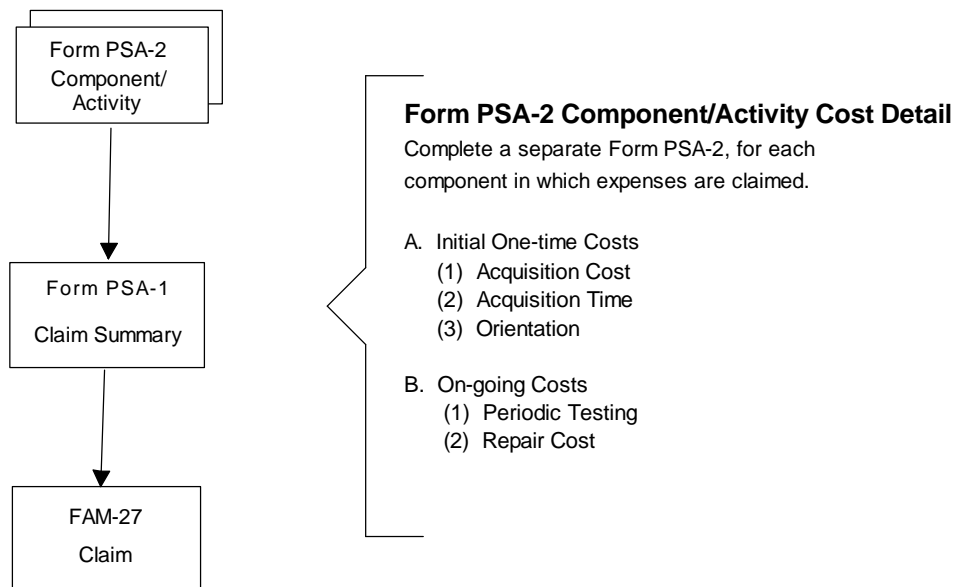
This form is used to summarize direct costs by component and compute allowable indirect costs for the mandate. The direct costs summarized on this form are derived from form PSA-2 and are carried forward to FAM-27.

Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits, as long as the direct labor costs are directly related to the cost of performing the mandate. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have its own ICRP for the program.

C. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the county. All applicable information from form PSA-1 must be carried forward to this form in order for the State Controller's Office to process the claim for payment.

ILLUSTRATION OF CLAIM FORMS



CLAIM FOR PAYMENT Pursuant to Government Code Section 17561 PERSONAL SAFETY ALARM DEVICES			For State Controller Use Only	
<div style="display: flex; align-items: center;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; margin-right: 5px;">LABORER</div> <div> (01) Claimant Identification Number (02) Mailing Address Claimant Name County of Location Street Address or P. O. Box City State Zip Code </div> </div>			(19) Program Number 00024 (20) Date File ____/____/____ (21) LRS Input ____/____/____	
			Reimbursement Claim Data	
			(22) PSA-1, (03)(1)	
			(23) PSA-1, (03)(2)	
<div style="display: flex;"> <div style="width: 30%;">Type of Claim</div> <div style="width: 30%;">Estimated Claim</div> <div style="width: 30%;">Reimbursement Claim</div> </div>			(24) PSA-1, (04)(1)(d)	
<div style="display: flex;"> <div style="width: 30%;">(03) Estimated <input type="checkbox"/></div> <div style="width: 30%;">(09) Reimbursement <input type="checkbox"/></div> </div>			(25) PSA-1, (04)(2)(d)	
<div style="display: flex;"> <div style="width: 30%;">(04) Combined <input type="checkbox"/></div> <div style="width: 30%;">(10) Combined <input type="checkbox"/></div> </div>			(26) PSA-1, (04)(3)(d)	
<div style="display: flex;"> <div style="width: 30%;">(05) Amended <input type="checkbox"/></div> <div style="width: 30%;">(11) Amended <input type="checkbox"/></div> </div>			(27) PSA-1, (04)(4)(d)	
Fiscal Year of Cost			(28) PSA-1, (06)	
(06)			(29)	
(12) 7/1/97 to 8/16/97			(30)	
Total Claimed			(31)	
(07)			(32)	
Less: 10% Late Penalty, not to exceed \$1000			(33)	
(14)			(34)	
Less: Estimated Claim Payment Received			(15)	
(16)			(35)	
Net Claimed Amount			(36)	
(17)			(37)	
Due from State			(18)	
(08)			(39) Name of Contact Person for Claim	
Due to State			Telephone Number	
(09)			(____) ____ Ext. ____	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Title 8, CCR Section 3401(c); and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Title 8, CCR Section 3401(c).

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Title 8, CCR Section 3401(c), set forth on the attached statements.

Signature of Authorized Representative

Date

Type or Print Name

Title

PERSONAL SAFETY ALARM DEVICES**Certification Claim Form****Instructions****FORM
FAM-27**

- (01) Leave blank.
- (02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the place shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.
- (03) to (08) Leave blank.
- (09) If filing a reimbursement claim, enter an "X" in the box on line (09) Reimbursement.
- (10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.
- (11) If filing an amended claim, enter an "X" in the box on line (11) Amended.
- (12) No entry required.
- (13) Enter the amount of reimbursement claim from form PSA-1, line (11).
- (14) If a reimbursement claim is filed after **June 25, 1999**, the claim must be reduced by a late penalty. Enter the product of multiplying line (13) by the factor 0.10 (10% penalty) or \$1,000, whichever is less.
- (15) No entry required.
- (16) Enter the result of subtracting line (14) from line (13).
- (17) Enter the amount from line (16) on line (17), Due from State.
- (18) to (21) Leave blank.
- (22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (28) for the reimbursement claim [e.g., PSA-1, (03)(1), means the information is located on form PSA-1, line (03)(1). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect cost percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35).
- (38) Read the statement "Certification of Claim." If the statement is true, the claim must be dated, signed by the agency's authorized representative and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.
- (39) Enter the name of the person and telephone number that this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

*Address, if delivered by
U.S. Postal Service:*

*Address, if delivered by
other delivery service:*

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250**

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816**

MANDATED COSTS PERSONAL SAFETY ALARM DEVICES CLAIM SUMMARY				FORM PSA-1
(01) Claimant		(02) Type of Claim Reimbursement Claimable Period for Costs 7/1/97 to 8/16/97		
Claim Statistics				
(03) 1. Number of personal safety alarm devices purchased.				
2. Total number of personal safety alarm devices repaired.				
Direct Costs		Object Accounts		
(04) Reimbursable Components:		(a) Salaries	(b) Benefits	(c) Services and Supplies
1. Initial One-time Costs				
2. On-going Costs				
(05) Total Direct Costs				
Indirect Costs				
(06) Indirect Cost Rate [From ICRP]				%
(07) Total Indirect Costs [Line (06) x line (05)(a)] or [line (06) x {line (05)(a) + line (05)(b)}]				
(08) Total Direct and Indirect Costs: [Line (05)(d) + line (07)]				
Cost Reduction				
(09) Less: Offsetting Savings, if applicable				
(10) Less: Other Reimbursements, if applicable				
(11) Total Claimed Amount [Line (08) - {Line (09) + Line (10)}]				

PERSONAL SAFETY ALARM DEVICES CLAIM SUMMARY Instructions	FORM PSA-1
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- (01) Enter the name of the claimant.
- (02) Type of Claim. No entry required.
- (03) 1. Enter the number of personal safety alarm devices purchased during the fiscal year.
2. Enter the number of personal safety alarm devices repaired during the fiscal year.
- (04) Reimbursable Components. For each reimbursable component enter the total from form PSA-2, line (05) columns (d), (e), and (f) to form PSA-1, block (04) columns (a), (b), and (c) in the appropriate row. Total each row.
- (05) Total Direct Costs. Total columns (a) through (d).
- (06) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have its own ICRP.
- (07) Total Indirect Costs. Multiply Total Salaries, line (05)(a) by the Indirect Cost Rate, line (06). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (05)(a), and Total Benefits, line (05)(b), by the Indirect Cost Rate, line (06).
- (08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(d) and Total Indirect Costs, line (07).
- (09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.
- (10) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including but not limited to, service fees collected, federal funds, other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.
- (11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10), from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (13), for the Reimbursement Claim.

MANDATED COSTS PERSONAL SAFETY ALARM DEVICES COMPONENT/ACTIVITY COST DETAIL					FORM PSA-2	
(01) Claimant			(02) Claimable Period of Costs: 7/1/97 to 8/16/97			
(03) Reimbursable Component: Check only one box per form to identify the component being claimed. <div style="margin-top: 10px;"> <input type="checkbox"/> Initial One-time Costs <input type="checkbox"/> On-going Costs </div>						
(04) Description of Expenses: Complete columns (a) through (f).			Object Accounts			
(a)	(b)	(c)	(d)	(e)	(f)	
Employee Names, Job Classifications, Functions Performed and Description of Services and Supplies	Hourly Rate or Unit Cost	Hours Worked or Quantity	Salaries	Benefits	Services and Supplies	
Acquisition cost of personal safety alarm device carried forward from form PSA-3						
(05) Total <input style="width: 50px;" type="text"/>			Subtotal <input style="width: 50px;" type="text"/>		Page: _____ of _____	

PERSONAL SAFETY ALARM DEVICES COMPONENT/ACTIVITY COST DETAIL Instructions	FORM PSA-2
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- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form PSA-2 shall be prepared for each component which applies.
- (04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, and supplies used. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits	Title						
	Activities	Benefit Rate	Hours Worked		Benefits = Benefit Rate x Salaries		
Services and Supplies							
Personal Safety Alarm Devices	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity	Purchase Invoice

- (05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component costs, number each page. Enter totals from line (05), columns (d), (e), and (f) to form PSA-1, block (04) columns (a), (b), and (c) in the appropriate row.

Structural and Wildland Firefighter's Safety Clothing and Equipment

1. Summary of Title 8, Sections 3401- 3410, CCR

Title 8, Sections 3401 through 3410 of the California Code of Regulations (CCR), requires local fire departments participating in structural and wildland fire suppression activities to provide specific types of protective clothing and equipment for fire fighting personnel.

On November 20, 1979, and March 18, 1981, the Board of Control, predecessor to the Commission on State Mandates, determined that these regulations resulted in state mandated costs that are reimbursable pursuant to Part 7 (commencing with Government Code Section 17500) of Division 4 of Title 2. The determination was made on November 20, 1979, for structural and March 18, 1981, for wildland.

2. Eligible Claimants

Any local agency fire department that performs structural fire suppression activities can claim increased costs incurred under Sections 3401-3409, CCR.

Any fire department that produces documentation that requires it to perform wildland fire suppression can claim increased costs incurred under Sections 3410, CCR. Documentation must consist of a contractual obligation to perform wildland fire suppression activity, membership in State Office of Emergency Services, and/or membership in the Master Mutual Aid Pact.

3. Reimbursable Components

The increased cost of specific types of clothing and equipment for structural and wildland firefighters is reimbursable only for purchases that occurred during the period 7/1/97 through 8/16/97 as follows:

A. Structural Firefighters

(1) Safety Clothing and Equipment

The cost of the following fire-fighting clothing and equipment, purchased after September 1, 1978, is reimbursable:

- (a) Turnout Coats
- (b) Turnout Pants
- (c) Gloves
- (d) Helmets
- (e) Goggles (there may be no increased cost)
- (f) Fire Retardant Pants (if necessary)
- (g) Leather Safety Shoes
- (h) Breathing Apparatus.

The cost of items (a) through (e) and item (h) must be reduced by the cost of similar equipment purchased prior to September 1, 1978, adjusted by annual changes in the implicit price deflator. Purchase orders, invoices, or other business records substantiating the purchase price of equipment before and after September 1, 1978, must be submitted with the claim.

As an alternative to substantiating the purchase price of clothing and equipment purchased prior to September 1, 1978, the average cost per item as listed below can be utilized as the 1978-79 base year cost. The average cost must be adjusted by annual changes in the implicit price deflator.

Turnout Coats	\$80.44
Turnout Pants	54.78
Gloves	4.58
Helmets	24.39
Goggles	3.67
Breathing Apparatus (New)	537.96
Breathing Apparatus (Conversion)	234.09

The cost of items (f) and (g) may be claimed in full since these items were not required before September 1, 1978. Claimant must have cost documentation (i.e., purchase orders, invoices, receipts, payment documents, or other business records) to substantiate purchase activities within the reimbursable 7/1/97 through 8/16/97 time period and payment of the items. Attach the invoice to the claim to show the purchase was made within the specific period. If the invoice is dated outside of the time frame, attach the invoice with the document that shows the purchase was within the time period.

(2) Conversion of Breathing Apparatus

If the local agency decides to convert the breathing apparatus, item (h), to comply with the mandated requirements, the following conversion costs are reimbursable:

- (a) Salaries and benefits of personnel converting the apparatus.
- (b) Purchase cost of conversion parts. Purchase orders, invoices, or other business records substantiating the purchase price must be submitted with the claim.
- (c) If a local agency is contracted for conversion of the breathing apparatus, the cost of the contract will be reimbursed. The contract and invoices must be submitted with the claim.

(3) Repairs and Maintenance

Costs related to the repair, spare and replacement parts, and maintenance costs associated with items 3.A.(1), (a) through (h) are reimbursable. Costs incurred to ensure the safe and proper operation of the equipment are reimbursable. However, cosmetic repairs unrelated to the effectiveness of the equipment will not be reimbursable.

For items 3.A.(1), (a) through (e) and (h), the State will reimburse claimants for the cost of repairs, spare and replacement parts, and maintenance to the extent that such costs exceed base year costs. To determine the reimbursable cost the claimant must first calculate the reimbursable percentage of repairs, spare and replacement parts, and maintenance. To calculate this percentage, the following formula may be used:

$$\frac{\text{Avg. Claiming Year Item Cost} - (\text{Base Year Cost} \times \text{Deflationary Factor})}{\text{Average Claim Year Item Cost}} \times 100 = \text{Reimbursable \%}$$

To determine the reimbursable cost in the claiming year, multiply the reimbursable percentage times the amount of repairs, spare and replacement parts, and

maintenance.

If in a fiscal year in which the cost of repairs, spare and replacement parts, and maintenance is being claimed and there are no corresponding items from (a) through (e) and (h), the claimant may utilize a cost for the item from the last fiscal year in which costs were incurred and adjust those costs, utilizing the approved state provided deflationary factors, to the current year being claimed. The above formula may then be utilized to arrive at the appropriate reimbursable percentage. For items 3.A.(1), (f) and (g), costs may be claimed in full for repairs, spare, and replacement parts, and maintenance.

B. Wildland Firefighters

(1) Safety Clothing and Equipment:

The cost of the following fire-fighting clothing and equipment purchased after November 3, 1978, is reimbursable:

- (a) Fire Retardant Jackets
- (b) Fire Retardant Pants
- (c) Fire Retardant Jump Suits
- (d) Ear and Nose Thermal Protection
- (e) Footwear
- (f) Helmets
- (g) Gloves
- (h) Face Shield

The cost of items (a) through (e) may be claimed in full because these items were not specifically required by the State prior to November 3, 1978. Claimant must have cost documentation (i.e., purchase orders, invoices, receipts, payment documents, or other business records) to substantiate purchase activities within the reimbursable 7/1/97 through 8/16/97 time period and payment of the items. Attach the invoice to the claim to show the purchase was made within the specific period. If the invoice is dated outside of the time frame, attach the invoice with the document that shows the purchase was within the time period.

The cost of items (f), (g), and (h) must be reduced by the cost of similar purchases made on or before November 3, 1978, adjusted by annual changes in the implicit price deflator.

As an alternative to substantiating the purchase price prior to November 3, 1978, the average cost per item as listed below can be utilized as the 1978-79 base year cost. The average must be adjusted by annual changes in the implicit price deflator.

Helmets	\$4.29
Gloves	4.83
Face Shield for Eye Protection	2.19

(2) Repairs and Maintenance

Costs related to the repair, spare and replacement parts, and maintenance costs associated with items 3.B.(1), (a) through (h) are reimbursable. Costs incurred to ensure the safe and proper operation of the equipment are reimbursable.

However, cosmetic repairs unrelated to the effectiveness of the equipment will not be reimbursable.

For items 3.B, (f) through (h), the State will reimburse claimants for the cost of repairs, spare and replacement parts, and maintenance to the extent that such costs exceed base year costs. To determine the reimbursable cost the claimant must first calculate the reimbursable percentage for repairs, spare and replacement parts, and maintenance. To calculate this percentage, the following formula may be used:

$$\frac{\text{Avg. Claiming Year Item Cost} - (\text{Base Year Cost} \times \text{Deflationary Factor})}{\text{Average Claim Year Item Cost}} \times 100 = \text{Reimbursement \%}$$

To determine the reimbursable cost in the claiming year, multiply the reimbursable percentage times the cost of repairs, spare and replacement parts, and maintenance.

If in a fiscal year in which the cost of repairs, spare and replacement parts, and maintenance is being claimed and there are no corresponding items from (f) through (h), the claimant may utilize a cost for the item from the last fiscal year in which costs were incurred and adjust those costs, utilizing the approved State provided deflationary factors, to the current year being claimed. The above formula may then be utilized to arrive at the appropriate reimbursable percentage.

For items 3.B, (a) through (e), costs may be claimed in full for repairs, spare and replacement parts, and maintenance.

4. Claiming Forms and Instructions

The diagram entitled "Illustration of Claim Forms" provides a graphic presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for forms FSC-1, FSC-2.1, FSC-2.2, FSC-2.3, FSC-2.4, FSC-2.5, and FSC-2.6 provided the format of the report and data fields contained within the report are identical to the claim forms included in this program. The claim forms provided for this program can be duplicated and used by the claimant to file a reimbursement claim.

A. Form FSC-2.2, Component/Activity Cost Detail

This form is used to detail costs of the conversion of breathing apparatus. The expenses reported on this form must be supported by cost and time records. Copies of supporting documentation as specified in the claiming instructions must be submitted with the claim.

B. Forms FSC-2.1 and FSC-2.4, Component/Activity Cost Detail

These forms are used to compute the increased cost of clothing and equipment purchased. As an alternative to substantiating the purchase price prior to the date indicated on the form, the average cost per item listed may be used. **The average cost must be adjusted by annual changes in the implicit price deflator.**

C. Forms FSC-2.3, FSC-2.5, and FSC-2.6, Component/Activity Detail

These forms are used to compute the cost of repairs and maintenance for structural and wildland firefighter's clothing and equipment. The total costs are carried forward from these forms to form FSC-1.

D. Form FSC-1, Claim Summary

This form is used to summarize direct costs from component/activity forms FSC-2.1, FSC-2.2, FSC-2.3, FSC-2.4, FSC-2.5, and indirect costs. The total costs from these forms are carried forward to form FAM-27.

Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits, as long as the direct labor costs are directly related to the cost of performing the mandate. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have its own ICRP.

E. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the county. All applicable information from form FSC-1 must be carried forward to this form in order for the State Controller's Office to process the claim for payment.

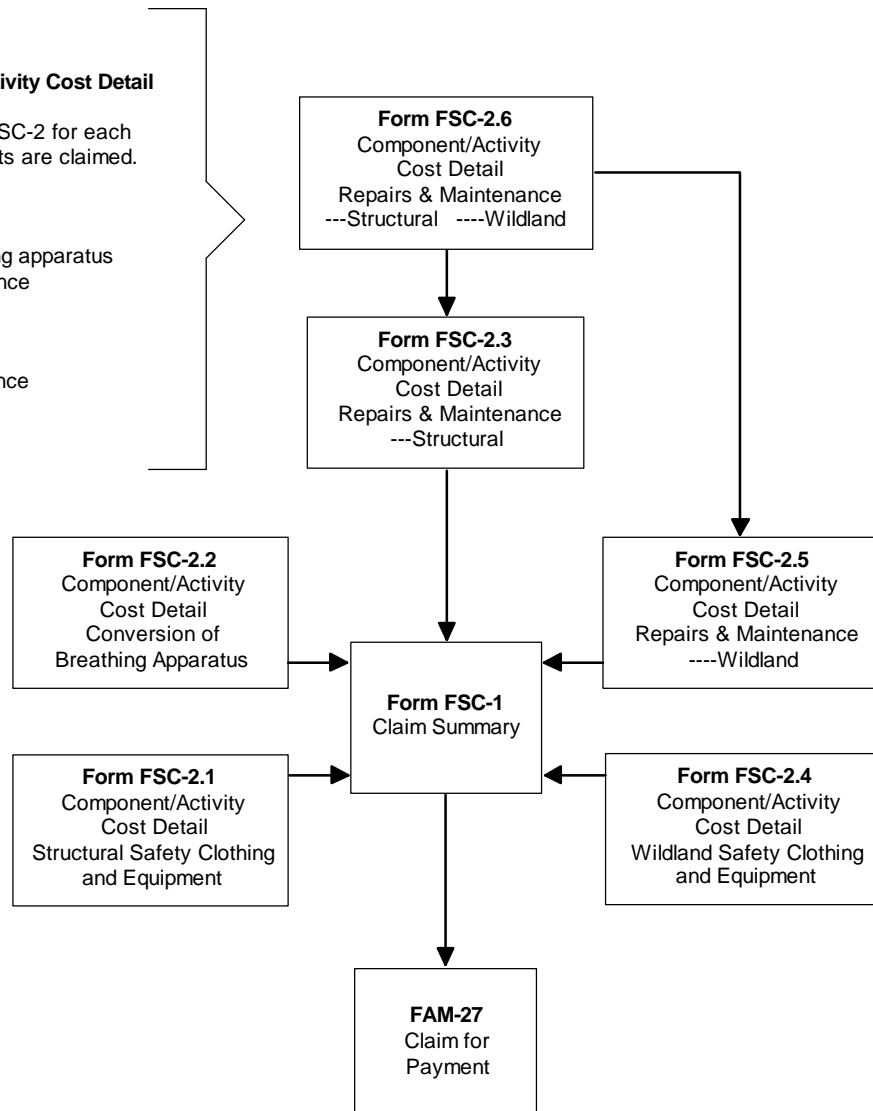
For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Illustration of Claim Forms

Form FSC-2 Component/Activity Cost Detail

Complete a separate Form FSC-2 for each cost component in which costs are claimed.

1. Structural Firefighters
 - A. Safety clothing
 - B. Conversion of breathing apparatus
 - C. Repairs and maintenance
2. Wildland Firefighters
 - A. Safety clothing
 - B. Repairs and maintenance



CLAIM FOR PAYMENT			For State Controller Use Only	
Pursuant to Government Code Section 17561 STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT			(19) Program Number 00064	
			(20) Date File _____/_____/_____	
			(21) LRS Input _____/_____/_____	
L A B E L H E R E	(01) Claimant Identification Number		Reimbursement Claim Data	
	(02) Mailing Address		(22) FSC-1, (03)(1)(A)(d)	
	Claimant Name		(23) FSC-1, (03)(1)(B)(d)	
	County of Location		(24) FSC-1, (03)(1)(C)(d)	
	Street Address or P. O. Box		(25) FSC-1, (03)(2)(A)(d)	
	City State Zip Code		(26) FSC-1, (03)(2)(B)(d)	
Type of Claim	Estimated Claim	Reimbursement Claim	(27) FSC-1, (05)	
	(03) Estimated <input type="checkbox"/>	(09) Reimbursement <input type="checkbox"/>	(28)	
	(04) Combined <input type="checkbox"/>	(10) Combined <input type="checkbox"/>	(29)	
	(05) Amended <input type="checkbox"/>	(11) Amended <input type="checkbox"/>	(30)	
Fiscal Year of Cost	(06)	(12) 7/1/97 to 8/16/97	(31)	
Total Claimed	(07)	(13)	(32)	
Less: 10% Late Penalty, not to exceed \$1000		(14)	(33)	
Less: Estimated Claim Payment Received		(15)	(34)	
Net Claimed Amount		(16)	(35)	
Due from State	(08)	(17)	(36)	
Due to State		(18)	(37)	
(38) CERTIFICATION OF CLAIM				
<p>In accordance with the provisions of Government Code 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Title 8, Section 3401 to 3410 of the California Code of Regulations (CCR); and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.</p> <p>I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Title 8, Section 3401 to 3410, CCR.</p> <p>The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Title 8, Section 3401 to 3410, CCR, set forth on the attached statemens.</p>				
Signature of Authorized Representative		Date		
_____		_____		
Type or Print Name		Title		
_____		_____		
(39) Name of Contact Person for Claim		Telephone Number		
_____		(_____) _____ Ext. _____		

STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT
Certification Claim Form
Instructions

**FORM
FAM-27**

- (01) Leave blank.
- (02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the place shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.
- (03) to (08) Leave blank.
- (09) If filing a reimbursement claim, enter an "X" in the box on line (09) Reimbursement.
- (10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.
- (11) If filing an amended claim, enter an "X" in the box on line (11) Amended.
- (12) No entry required.
- (13) Enter the amount of reimbursement claim from form FSC-1, line (10).
- (14) If a reimbursement claim is filed after **June 25, 1999**, the claim must be reduced by a late penalty. Enter the product of multiplying line (13) by the factor 0.10 (10% penalty) or \$1,000, whichever is less.
- (15) No entry required.
- (16) Enter the result of subtracting line (14) from line (13).
- (17) Enter that amount from line (16) on line (17), Due from State.
- (18) to (21) Leave blank.
- (22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (27) for the reimbursement claim (e.g., FSC-1, (03)(a), means the information is located on form FSC-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect cost percentage should be shown as a whole number without the percentage symbol (i.e., 35% should be shown as 35).
- (38) Read the statement "Certification of Claim." If the statement is true, the claim must be dated, signed by the agency's authorized representative, and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.
- (39) Enter the name of the person and telephone number that this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

*Address, if delivered by
U.S. Postal Service:*

*Address, if delivered by
other delivery service:*

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250**

**OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816**

MANDATED COSTS STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT CLAIM SUMMARY				FORM FSC-1
(01) Claimant	(02) Type of Claim Reimbursement Claimable Period of Costs 7/1/97 to 8/16/97			
Direct Costs	Object Accounts			
(03) Reimbursable Components:	(a) Salaries	(b) Benefits	(c) Services and Supplies	(d) Total
1. Structural Firefighters				
A. Safety Clothing and Equipment				
B. Conversion of Breathing Apparatus				
C. Repairs and Maintenance				
2. Wildlands Firefighters				
A. Safety Clothing and Equipment				
B. Repairs and Maintenance				
(04) Total Direct Costs				
Indirect Costs				
(05) Indirect Cost Rate	[From ICRP]			%
(06) Total Indirect Costs	[Line (05) x line (04)(a)] or [line (05) x {line (04)(a) + line (04)(b)}]			
(07) Total Direct and Indirect Costs:	[Line (04)(d) + line (06)]			
Cost Reduction				
(08) Less: Offsetting Savings, if applicable				
(09) Less: Other Reimbursements, if applicable				
(10) Total Claimed Amount	[Line (07) - {Line (08) + Line (09)}]			

STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT CLAIM SUMMARY Instructions	FORM FSC-1
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- (01) Enter the name of the claimant.
- (02) Type of Claim. No entry required.
- (03) Enter the number of cost from forms FSC-2.1, FSC-2.2, FSC-2.3, and FSC-2.4, line (05) to form FSC-1, block (03) columns (a), (b), and (c), in the appropriate row. Total each row.
- (04) Total Direct Costs. Total columns (a) through (d).
- (05) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is reporting costs, each must have its own ICRP.
- (06) Total Indirect Costs. Multiply Total Salaries, line (04)(a) by the Indirect Cost Rate, line (05). If both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (04)(a), and Total Benefits, line (04)(b), by the Indirect Cost Rate, line (05).
- (07) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (04)(d), and Total Indirect Costs, line (06).
- (08) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.
- (09) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.
- (10) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (09), from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (13) for the Reimbursement Claim.

MANDATED COSTS STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT COMPONENT/ACTIVITY COST DETAIL								FORM FSC-2.1
(01) Claimant				(02) Claimable Period of Costs: 7/1/97 to 8/16/97				
(03) Reimbursable Component: Structural Firefighter -- Safety Clothing and Equipment								
(04) Description of Expenses: Complete columns (a) through (g).								
Clothing and Equipment	Increased Cost Per Unit Purchased							Object Account
	(a) Costs on or Before 9/1/78		(b)	(c)	(d)	(e)	(f)	(g)
	Average Costs	Actual Purchase	Inflation Factors	Adjusted Costs	Current Costs	Increased Costs	Number of Items Purchased	Services and Supplies
1. Turnout Coats	\$ 80.44							
2. Turnout Pants	\$ 54.78							
3. Gloves	\$ 4.58							
4. Helmets	\$ 24.39							
5. Goggles	\$ 3.67							
6. Fire Retardant Pants								
7. Leather Safety Shoes								
8. Breathing Apparatus, New	\$							
9. Breathing Apparatus, Conversion	\$							
(05) Total								

STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT
COMPONENT/ACTIVITY COST DETAIL
Instructions

**FORM
FSC-2.1**

- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Reimbursable Components. Wildland Firefighters--Safety Clothing and Equipment. This line identifies the cost which may be claimed on form FSC-2.1.
- (04) The costs of safety clothing and equipment to be claimed must be reduced by the costs of similar clothing and equipment prior to September 1, 1978. The columns in block (04) are explained as follows:

(a) Costs on or before 9/1/78 has two columns. Claimants have the option of using either of the columns as the starting point to compute reimbursable costs for each type of clothing and equipment. Columns in (a) show the cost per item. If the claimant has cost records for purchases made prior to 9/1/78, those costs may be shown in the column "Actual Purchased Costs" and the fiscal year in which the prior purchases were made indicated. If such cost records do not exist, you can use the costs given in the column "Average Costs" -- costs of items in the 1978/79 fiscal year.

(b) Inflation Factors. Enter the appropriate inflation factor for each type of safety clothing and equipment from the following table. Example: If you are using a 1975/76 receipt for the costs of helmets, enter the factor 2.6943 for helmets in column (b). If you have no receipts/cost records for the fiscal years listed, enter the 1978/79 factor 2.2250 for helmets in column (b).

Inflation Factors for Purchases Made in 1997/98

Base Years	Factors
1978-79	2.2250
1977-78	2.3836
1976-77	2.5493
1975-76	2.6943
1974-75	2.9079
1973-74	3.2672
1972-73	3.5421
1971-72	3.7900
1970-71	4.0177

* Source: State Department of Finance, "National Deflators, State and Local Purchases." July 31, 1998.

- (c) Adjusted Costs. Multiply an amount from column (a) by column (b) to reflect what the similar safety clothing & equipment would cost at the 1997-98 price.
- (d) Current Costs. Enter the current purchase cost per item for each type of safety clothing and equipment purchased. Attach the invoice with the claim that shows the purchase was made within the 7/1/97 through 8/16/97 time period. If the invoice is dated outside of the 7/1/97 to 8/16/97 time period, attach the invoice with the document that shows the purchase activity was within the time period.
- (e) Increased costs. Subtract the amount in column (c) from column (d). A positive difference is the amount of increased costs per item.
- (f) Numbers of Items Purchased. Enter the number of items purchase during the claim period for each type of safety clothing and equipment.
- (g) Services and Supplies. Multiply column (e) by column (f) to obtain the total increased costs for each type of safety clothing and equipment.
- (05) Total column (g) and Services and Supplies. Forward the total to from FSC-1, line (03)(1)(A), column (c).

[illegible]

**STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT
COMPONENT/ACTIVITY COST DETAIL
Instructions**

**FORM
FSC-2.2**

- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Reimbursable Component: Structural Firefighter -- Breathing Apparatus Conversion. This line identifies the costs which may be claimed on form FSC-2.2.
- (04) The following table identifies reimbursable costs and type of information required to support these costs. To claim costs incurred for conversion of breathing apparatus, enter the employee names, position titles, a brief description of the activities performed, productive hourly rate, and fringe benefits. If the conversion was performed by an outside contractor, enter the name of the contractor, a description and date when tasks were performed, and the cost of such services. Attach all contractor's invoices as support for the claim. The cost of parts for the breathing apparatus conversion is claimed on form FSC-2.1, line (04)(9).

For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits	Title	Benefit Rate	Hours Worked		Benefits = Benefit Rate x Salaries		
	Activities						
Services and Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Used	
Contract Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service			Itemized Cost of Services Performed	Invoice

- (05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/ activity costs, number each page. Enter totals from line (05), columns (d), (e), and (f) to form FSC-1, block (03), line (1)(B), columns (a), (b), and (c), respectively.

MANDATED COSTS STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT COMPONENT/ACTIVITY COST DETAIL								FORM FSC-2.3
(01) Claimant				(02) Claimable Period of Costs: 7/1/97 to 8/16/97				
(03) Reimbursable Component: Structural Firefighter-Safety Clothing and Equipment -Repair and Maintenance								
(04) Description of Expenses: Complete columns (a) through (g).								
Clothing and Equipment	Increased Cost Per Unit Purchased						Object Account	
	(a) Costs on or Before 9/1/78		(b)	(c)	(d)	(e) Col D-C/ Col D x 100 % of Reimbursable	(f) Cost of Repair & Maintenance in Claiming Year	(g)
	Average Costs	Actual Purchase	Inflation Factors	Adjusted Costs	Current Costs			Services and Supplies
1. Turnout Coats	\$ 80.44							
2. Turnout Pants	\$ 54.78							
3. Gloves	\$ 4.58							
4. Helmets	\$							
5. Goggles	\$ 3.67							
6. Fore Retardant Pants						100%		
7. Leather Safety Shoes						100%		
8. Breathing Apparatus, New	\$ 537.96							
(05) Total								

**STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT
COMPONENT/ACTIVITY COST DETAIL**

**FORM
FSC-2.3**

Instructions

- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Reimbursable Components. Structural Firefighters--Repairs and Maintenance of Safety Clothing Equipment. This line identifies the cost which may be claimed on form FSC-2.3.
- (04) The costs of repairs, spare and replacement parts and maintenance (RSRPM) for structural safety clothing and equipment to be claimed to the extent that such cost exceed the base year cost. The columns in block (04) are explained as follows:
- (a) Costs on or before 9/1/78 has two columns. Claimants have the option of using either of the columns as the starting point to compute reimbursable costs for RSRPM or each type of clothing and equipment. If the claimant has cost records showing the actual cost per item prior to 9/1/78, those costs may be shown in the column "Actual Costs" and the fiscal year in which the costs apply indicated. If such cost records do not exist, you can use the costs from the most recent fiscal year in which costs were incurred and adjust those costs by the inflation factors. In the absence of the aforementioned, the claimant may use costs shown in the column "Average" as the 1978/79 base year cost. The columns in (a) reflect a per item cost.
- (b) Inflation Factors. Enter the appropriate inflation factor which corresponds with the fiscal year which you have receipts/records of costs for each type of safety clothing and equipment. If the "Average Cost" is used, enter the inflation factor shown for the 1978/79 fiscal year. These factors will convert any prior fiscal year costs to a 1991/92 dollar value

Base Years	Factors	Base Years	Factors
1996-97	1.0179	1982-83	1.5858
1995-96	1.0403	1981-82	1.6795
1994-95	1.0676	1980-81	1.8076
1993-94	1.0986	1979-80	2.0088
1992-93	1.1224	1978-79	2.2250
1991-92	1.1496	1977-78	2.3836
1990-91	1.1758	1976-77	2.5493
1989-90	1.2292	1975-76	2.6943
1988-89	1.2804	1974-75	2.9079
1987-88	1.3160	1973-74	3.2672
1986-87	1.3649	1972-73	3.5421
1985-86	1.4124	1971-72	3.7900
1984-85	1.4577	1970-71	4.0177
1983-84	1.5221		

* Source: State Department of Finance, "National Deflators, State and Local Purchases." July 31, 1998.

- (c) Adjusted Costs. Multiply an amount from column (a) by column (b). The product reflects the prior year cost in current dollars.
- (d) Current Costs. Enter the current purchase cost per item for each type of safety clothing and equipment claimed. Attach an invoice with the claim that shows the purchase was made within the 7/1/97 through 8/16/97 time period. If the invoice is dated outside of this time period, attach the invoice with the document that shows the purchase activity was within the time period.
- (e) [Columns (d) - (c)/ Column (d)] x 100 = % Reimbursable. This formula shall be used to determine what percentage of the current costs would be eligible for reimbursement. Calculation is not required for fire retardant pants and leather safety shoes because these are fully reimbursable
- (f) Costs of Repairs and Maintenance in the Claiming Year. Enter the current costs of RSRPM from form FSC-2.6, in column (f) as applicable, for each type of safety clothing and equipment.
- (g) Services and Supplies. Multiply column (e) by column (f) to obtain the RSRPM costs for each type of safety clothing and equipment.
- (05) Total column (g) and Services and Supplies. Forward the total to from FSC-1, line (03)(1)(C), column (c).

MANDATED COSTS STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT COMPONENT/ACTIVITY COST DETAIL								FORM FSC-2.4
(01) Claimant				(02) Claimable Period of Costs: 7/1/97 to 8/16/97				
(03) Reimbursable Component: Wildland Firefighter -- Safety Clothing and Equipment								
(04) Description of Expenses: Complete columns (a) through (g).								
Clothing and Equipment Purchased after November 3, 1978	Increased Cost Per Unit Purchased							Object Account
	(a) Costs on or Before 11/3/78		(b)	(c)	(d)	(e)	(f)	(g)
	Average Costs	Actual Purchase	Inflation Factors	Adjusted Costs	Current Costs	Increased Costs	Number of Items Purchased	Services and Supplies
1. Fire Retardant Jackets								
2. Fire Retardant Pants								
3. Fire Retardant Jump Suits								
4. Ear & Neck Thermal Protection								
5. Footwear								
6. Helmet	\$ 4.29							
7. Gloves	\$ 4.83							
8. Face Shield	\$ 2.19							
(05) Total								

**STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT
COMPONENT/ACTIVITY COST DETAIL
Instructions**

**FORM
FSC-2.4**

- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Reimbursable Components. Wildland Firefighters--Safety Clothing and Equipment. This line identifies the cost which may be claimed on form FSC-2.4.
- (04) The costs of safety clothing and equipment to be claimed must be reduced by the costs of similar clothing and equipment prior to November 3, 1978. The columns in block (04) are explained as follows:
- (a) Costs on or before 11/3/78 has two columns. Claimants have the option of using either of the columns as the starting point to compute reimbursable costs for each type of clothing and equipment. Columns in (a) show the cost per item. If the claimant has cost records for purchases made prior to 11/3/78, those costs may be shown in the column "Actual Purchased Costs" and the fiscal year in which the prior purchases were made indicated. If such cost records do not exist, you can use the costs given in the column "Average Costs" -- costs of items in the 1978/79 fiscal year.
- (b) Inflation Factors. Enter the appropriate inflation factor for each type of safety clothing and equipment from the following table. Example: If you are using a 1975/76 receipt for the costs of helmets, enter the factor 2.6943 for helmets in column (b). If you have no receipts/cost records for the fiscal years listed, enter the 1978/79 factor 2.2250 for helmets in column (b).

Inflation Factors for Purchases Made in 1997/98

Base Years	Factors
1978-79	2.2250
1977-78	2.3836
1976-77	2.5493
1975-76	2.6943
1974-75	2.9079
1973-74	3.2672
1972-73	3.5421
1971-72	3.7900
1970-71	4.0177

* Source: State Department of Finance, "National Deflators, State and Local Purchases." July 31, 1998.

- (c) Adjusted Costs. Multiply an amount from column (a) by column (b) to reflect what the similar safety clothing & equipment would cost at today's price.
- (d) Current Costs. Enter the current purchase cost per item for each type of safety clothing and equipment purchased. Attach the invoice with the claim that shows the purchase was made within the 7/1/97 through 8/16/97 time period. If the invoice is dated outside of this time period, attach the invoice with the document that shows the purchase activity was within the time period.
- (e) Increased costs. Subtract the amount in column (c) from column (d). A positive difference is the amount of increased costs per item.
- (f) Numbers of Items Purchased. Enter the number of items purchase during the claim period for each type of safety clothing and equipment.
- (g) Services and Supplies. Multiply column (e) by column (f) to obtain the total increased costs for each type of safety clothing and equipment.
- (05) Total column (g) and Services and Supplies. Forward the total to from FSC-1, line (03)(2)(A), column (c).

MANDATED COSTS STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT COMPONENT/ACTIVITY COST DETAIL								FORM FSC-2.5
(01) Claimant				(02) Claimable Period of Costs: 7/1/97 to 8/16/97				
(03) Reimbursable Component: Wildland Firefighter -- Safety Clothing and Equipment								
(04) Description of Expenses: Complete columns (a) through (g).								
Clothing and Equipment	Increased Cost Per Unit Purchased							Object Account
	(a) Costs on or Before 9/1/78		(b)	(c)	(d)	(e) Col D-C/ Col D x 100 % of Reimbur-s able	(f) Costs of Repair & Mainten- ance in Claiming Year	(g) Services and Supplies
	Average Costs	Actual Purchase Costs	Inflation Factors	Adjusted Costs	Current Costs			
1. Fire Retardant Jackets						100%		
2. Fire Retardant Pants						100%		
3. Fire Retardant Jump Suits						100%		
4. Ear & Neck Thermal Protection						100%		
5. Footwear						100%		
6. Helmet	\$ 4.29							
7. Gloves	\$ 4.83							
8. Face Shield	\$ 2.19							
(05) Total								

STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT
COMPONENT/ACTIVITY COST DETAIL
Instructions

FORM
FSC-2.5

- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Reimbursable Components. Structural Firefighters--Repairs and Maintenance of Safety Clothing Equipment. This line identifies cost which may be claimed on form FSC-2.5.
- (04) The costs of repairs, spare and replacement parts and maintenance (RSRPM) for structural safety clothing and equipment to be claimed to the extent that such cost exceed the base year cost. The columns in block (04) are explained as follows:
- (a) Costs before 9/1/78 has two columns. Claimants have the option of using either of the columns as the starting point to compute reimbursable costs for each type of clothing and equipment. Columns in (a) show the cost per item. If the claimant has cost records showing the actual cost per item prior to 9/1/78, those costs may be shown in the column "Actual Costs" and the fiscal year in which the costs apply indicated. If such cost records do not exist, you can use costs for the most recent fiscal year in which costs were incurred and adjust those costs by the inflation factors. In the absence of the aforementioned, the claimant may use costs shown in the column "Average" as the 1978/79 base year cost. The columns in (a) reflect a per item cost.
- (b) Inflation Factors. Enter the appropriate inflation factor which corresponds with the fiscal year which you have receipts/records of costs for each type of safety clothing and equipment. If the "Average Cost" is used, enter the inflation factor shown for the 1991/92 fiscal year. These factors will convert any prior fiscal year costs to a 1991/92 dollar value.

Base Years	Factors	Base Years	Factors
1996-97	1.0179	1982-83	1.5858
1995-96	1.0403	1981-82	1.6795
1994-95	1.0676	1980-81	1.8076
1993-94	1.0986	1979-80	2.0088
1992-93	1.1224	1978-79	2.2250
1991-92	1.1496	1977-78	2.3836
1990-91	1.1758	1976-77	2.5493
1989-90	1.2292	1975-76	2.6943
1988-89	1.2804	1974-75	2.9079
1987-88	1.3160	1973-74	3.2672
1986-87	1.3649	1972-73	3.5421
1985-86	1.4124	1971-72	3.7900
1984-85	1.4577	1970-71	4.0177
1983-84	1.5221		

* Source: State Department of Finance, "National Deflators, State and Local Purchases." July 31, 1998.

- (c) Adjusted Costs. Multiply an amount from column (a) by column (b). The product reflects the prior year cost in current dollars.
- (d) Current Costs. Enter the current purchase cost per item for each type of safety clothing and equipment purchased.
- (e) $[\text{Column (d)} - \text{Column (c)}] \times 100 = \% \text{ Reimbursable}$. This formula shall be used to determine what percentage of the current costs would be eligible for reimbursement. Calculation is only required for helmets, gloves and face shields.
- (f) Costs of Repairs and Maintenance in the Claiming Year. Enter the current costs of RSRPM from form FSC-2.5, column (f), as applicable, for each type of safety clothing and equipment.
- (g) Services and Supplies. Multiply column (e) by column (f) to obtain the RSRPM costs for each type of safety clothing and equipment.
- (05) Total column (g) and Services and Supplies. Forward the total to form FSC-1, line (03)(2)(B), column (c).

MANDATED COSTS STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT COMPONENT/ACTIVITY COST DETAIL					FORM FSC-2.6	
(01) Claimant			(02) Claimable Period of Costs: 7/1/97 to 8/16/97			
(03) Reimbursable Component: Check only one box per form to identify the component being claimed.						
<input type="checkbox"/> Structural Firefighters -- Repairs and Maintenance <input type="checkbox"/> Wildland Firefighters -- Repairs and Maintenance						
(04) Description of Expenses: Complete columns (a) through (f).					Object Accounts	
(a)	(b)	(c)	(d)	(e)	(f)	
Employee Names, Job Classifications, Functions Performed and Description of Services and Supplies	Hourly Rate or Unit cost	Hours Worked or Quantity	Salaries	Benefits	Services and Supplies	
Detail and summarize costs by type of clothing and equipment.						
(05) Total <input style="width: 50px;" type="text"/>			Subtotal <input style="width: 50px;" type="text"/>		Page: _____ of _____	

**STRUCTURAL AND WILDLAND FIREFIGHTER'S SAFETY CLOTHING AND EQUIPMENT
COMPONENT/ACTIVITY COST DETAIL**

Instructions

**FORM
FSC-2.6**

- (01) Enter the name of the claimant.
- (02) No entry required.
- (03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form.
- (04) Description of Expenses. The following table identifies reimbursable cost and type of information required to support the claim. Enter the cost of repairs and maintenance for safety clothing and equipment. Costs should be identified by type of clothing and equipment. Enter the employee name or position title of the person who performed repairs and maintenance, give a brief description of the activities performed, the person's productive hourly rate, fringe benefits, and the cost of replacement parts. If repairs and maintenance were performed by an outside contractor, enter the name of the contractor, the description and date of service and the cost of such services. Attach all contractor invoices to support the claim. Attach a separate sheet if more space is required.

For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. Such documents shall be made available to the State Controller's Office on request.

Object/ Subobject Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name	Hourly Rate	Hours Worked	(b) x (c) = Hourly Rate x Hours Worked			
Benefits	Title						
	Activities Performed	Benefit Rate	Hours Worked		(b) x (d) = Benefit Rate x Salaries		
Services and Supplies							
Replacement Parts	Description of Repaired	Itemize Cost of Parts	Number of Parts		Total Cost Claimed		Invoice
Contract Services	Name of Contractor	Hourly Rate	Hours Worked		Itemized Cost of Services Performed		Invoice
	Specific Tasks Performed		Inclusive Dates of Service				

- (05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amounts a total or subtotal.

If the reimbursable component is Structural Firefighters--Repairs and Maintenance, total line (05), columns (d), (e), and (f) ad forward the total amount to form FSC-2.3, column (f), in the appropriate row of the safety clothing and equipment.

If the reimbursable component is Wildlands Firefighters--Repairs and Maintenance, total line (05), columns (d), (e), and (f) and forward the total amount to form FSC-2.5, column (f), in the appropriate row of the safety clothing and equipment.